



STATE OF TENNESSEE
RFP # 318.66-053
AMENDMENT # 2

February 21, 2008

THE SUBJECT RFP IS HEREBY AMENDED AS FOLLOWS.

A. The following RFP Schedule of Events updates or confirms scheduled RFP dates.

EVENT	TIME	DATE	UPDATED/ CONFIRMED
1. State Issues RFP		January 7, 2008	CONFIRMED
2. Disability Accommodation Request Deadline		January 14, 2008	CONFIRMED
3. Pre-proposal Conference	2:00 p.m.	January 16, 2008	CONFIRMED
4. Notice of Intent to Propose Deadline		January 23, 2008	CONFIRMED
5. Written Comments Deadline		January 28, 2008	CONFIRMED
6. State Responds to Written Comments		February 21, 2008	CONFIRMED
7. Proposal Deadline	2:00 p.m.	March 12, 2008	UPDATED
8. State Completes Technical Proposal Evaluations		April 8, 2008	UPDATED
9. Proposer Oral Evaluations		April 9 – April 18, 2008	UPDATED
10. State Opens Cost Proposals and Calculates Scores	9:00 a.m.	April 21, 2008	CONFIRMED
11. State Issues Evaluation Notice <u>and</u> Opens RFP Files for Public Inspection	9:00 a.m.	April 22, 2008	CONFIRMED
12. Contract/Agreement Signing		May 2, 2008	CONFIRMED
13. Contract/Agreement Signature Deadline		May 9, 2008	CONFIRMED
14. Contract/Agreement Start Date (Readiness Review/Transition Begins)		May 12, 2008	CONFIRMED
15. Delivery of Services for West Grand Region		November 1, 2008	CONFIRMED
16. Delivery of Services for East Grand Region		January 1, 2009	CONFIRMED

B. The following State Responses to the questions detailed shall amend or clarify the RFP accordingly.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
1	General	NA	NA	Define reduction in services -- would this include moving a member from the ICU to an acute bed? Moving a member from an acute inpatient bed to a skilled bed?	The State is unable to answer the question due to the lack of specificity of the situation and without the context of the question.
2	General	NA	NA	Are the specific pharmacy requirements in Grier applicable to the injectables and infusion pharmacy services that are not carved out from the MCC's services?	There are no specific requirements related to injectables and home infusion services. The MCOs should follow the documented requirements for other medical services.
3	General	NA	NA	At the inception of the contract award, once membership is transferred to the MCC, will Adverse Action notices per Grier need to be mailed to members whose PCPs or other treating providers are not in the MCC's existing network, but were in the member's previous MCC's provider network? Will the state provide member PCP data to the winning MCCs prior to contract inception to ensure continuity of care across MCCs?	Members will receive a letter from the State notifying them that their MCC is changing. This notification will explain to the member how to find out what providers are in the new MCOs network and how to request a change in MCO. The notification will also advise enrollees of their appeal rights. The MCOs will be responsible for providing additional notification to the member about their MCO and network, including the member's PCP assignment. Since the member has the opportunity to request a different PCP or a different MCO, an adverse action notice is not required. The State will provide member PCP data to the contractors after contract award.
4	General	NA	NA	What member health related data will the state provide the plan and how often? For example, some states provide a monthly list of pregnant women to assist with high risk pregnancy identification(s).	The State will not provide ongoing health related data to the MCOs.
5	General	NA	NA	Is the 1999 Standard Operating Procedures for EPSDT, referenced in the John B court documents, available?	Yes, on the TennCare website at http://www.state.tn.us/tenncare/pol-036.html .
6	General	NA	NA	Does the state provide the Family Case Unit on the 834 eligibility files?	Yes. The 834 eligibility files include the member's case number (head-of-household SSN).
7	General	NA	NA	Is there a family identifier on the enrollment file that will link members of a family?	Yes. Refer to State's Response #6.
8	General	NA	NA	What lessons has the Bureau learned from the Middle Grand Region's implementation that might inform bidder responses for the East and West Grand Regions?	Lessons learned from the Middle implementation include the importance of: having a partnership and ongoing communication with the MCOs, including regularly scheduled meetings; the MCO having staff on the ground in Tennessee; the MCO beginning provider network development, including face-to-face meetings with providers, as soon as possible; the importance and challenges of identifying members who will need transition of care, including transportation; the MCO conducting its own systems testing; and the MCO having a fully-staffed and functional call center, particularly for transportation.
9	General	NA	NA	Please provide the following information (10 lines) regarding TennCare Members:	While the State understands that this information would assist proposers in preparing proposals, the State will not be able to provide this information prior to the proposal deadline. Information by diagnoses and procedure codes is provided in the data books (RFP Attachments 6.14 and 6.15).
10	General	NA	NA	% of TennCare Members with diabetes, by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
11	General	NA	NA	% of TennCare Members with high risk pregnancies by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
12	General	NA	NA	% of TennCare Members with Congestive heart failure by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
13	General	NA	NA	% of TennCare Members with Asthma by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
14	General	NA	NA	% of TennCare Members with Coronary artery disease by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
15	General	NA	NA	% of TennCare Members with COPD by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
16	General	NA	NA	% of TennCare Members with bipolar disorder by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
17	General	NA	NA	% of TennCare Members with major depression by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
18	General	NA	NA	% of TennCare Members with schizophrenia by race or ethnicity, age and geographic location (urban/ rural)	Refer to State's Response #9.
19	General	NA	NA	% of TennCare Members who are obese by race or ethnicity, age, and geographic location. (urban/ rural)	Refer to State's Response #9.

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20	General	NA	NA	Will the State supply member-specific data to facilitate continuity of care and PCP assignment?	Yes. The State will provide member-specific enrollment and claims/encounter data prior to the start date of operations.
21	General	NA	NA	Can the state provide historical data from the behavioral health contract for use in Disease Management?	The data is available from the BHO and can be supplied to the contractors after contract award.
22	General	NA	NA	Can copies of the most recent EQRO reports on TennCare MCOs be made available?	Yes. The State will send copies of these reports to all proposers that submitted a Notice of Intent to Propose.
23	RFP	1.1	3	To increase competition between bidders in either the East or West Grand Region, will the State consider awarding contracts to three bidders in each region, instead of two?	No. The State will award two contracts in each region.
24	RFP	1.1	4	Is the State going to further actively pursue getting the Grier V. Goetz decision reversed or modified?	No. We do not anticipate seeking to reverse or modify the decree in Grier in the foreseeable future.
25	RFP	1.1	4	Under the Grier consent decree, is a move of a member from a hospital intensive care unit to another type of acute care bed within the same hospital considered a reduction in service and hence an adverse action?	If a member is moved from a hospital intensive care to another type of acute care bed within the same hospital on the treating physician's order, it is not considered an adverse action. However, if the treating physician's order is for the member to remain in intensive care and the MCO is refusing authorization, it is considered an adverse action which would require appropriate notification to the member.
26	RFP	1.1	4	Does changing the member's PCP or specialist upon start up of operations (after best efforts to match the member's providers to our panel) constitute an adverse action and require a Grier letter?	Refer to State's Response #3.
27	RFP	1.1	5	For Middle Tennessee, were the cost component of the bids for the two carriers awarded the contracts at the minimum acceptable capitation amount as published in the RFP?	Yes. The two proposers awarded contracts in Middle bid the minimum rates.
28	RFP	1.1	5	For Middle Tennessee, the two carriers awarded the contract have been operational for 9 months. What is the most recent year-to-date medical loss ratio as reported to the Bureau of TennCare for these two carriers?	The Bureau does not believe that this information is pertinent to this RFP.
29	RFP	1.1	5	On page 5, it is stated, "Eligibility and membership in the program has stabilized". In examining the changes in enrollment mix between SFY 2006 and SFY 2007 for the Western Region, significant changes occurred. What is the basis for the statement that eligibility and membership has stabilized? What is the current distribution for SFY 2008?	While there have been some changes within certain rate cells, overall enrollment in TennCare and across major categories (Medicaid Duals, Medicaid Non-Duals, Medically Needy, and TennCare Standard) has been stable over the last couple of years. The enrollment as of 12/30/07 is distributed as follows: 51,420 Medicaid Duals; 296,164 Medicaid Non-Duals; 22,340 Medically Needy; and 7,929 TennCare Standard enrollees.
30	RFP		5	The RFP indicates that the state will provide requirements for the web site. When will those requirements be provided?	The question is unclear. The State has posted the items listed in RFP Attach 6.5 (Procurement Library) on its website at http://tennessee.gov/tenncare/news-rfp.html .
31	RFP	1.5.10	7	In accordance with RFP Section 1.5.10, please provide written consent to rely on the data contained in both Attachment 6.14 and 6.15 for East and West Tennessee Grand Regions, respectively, specifically as it relates to the Home Health and Private Duty Nursing.	The State hereby provides written consent that the proposers may rely on the information and data in the RFP and its attachments, including the data books and any amendments to the RFP. Note that this is the best information and data that we have.

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32	RFP	2	9	The State plans to post answers to questions on February 21. Given that Sections 4.5 and 4.6 of the pro forma contract indicate that the RFP, RFP associated amendments and the MCO's proposal constitute the resulting "entire agreement" for this procurement, a 2-week period between when the State responds to questions and the proposal due date may challenge a proposer's ability to adequately incorporate additional information and/or clarification into its proposal. Will the State consider: (a) posting the answers to the questions one week earlier, on February 14th; (b) alternatively, posting a significant portion of the answers to the questions by the February 14th date, with the remainder on February 21st; (c) delaying the proposal due date by one week, to March 13th?	The State respects the proposers' need to review and incorporate the State's responses to questions in their proposals. Based on our review of the questions, we do not think that the responses will significantly impact the content of the proposers' proposals. However, the timeframes have been changed. Refer to Section A of this amendment.
33	RFP	3.1.2.3	10	Do the completed contact memorandums need to be included in the narrative MS Word file (as referenced in 3.1.2.3) or is it acceptable for these to be included as attachments in PDF format only?	The proposer shall include the contact memorandums in its PDF file but may exclude the contact memorandums from the MS Word file. Note the contact memorandums shall not be included as an attachment but rather as part of Section D (after the applicable Guide to Section D). Refer to Section 3.2.3 of the RFP.
34	RFP	3.1.2.1	10	Regarding the 8 copies for submission, how should we address this with sealed client references?	The proposer shall submit the original client references in their sealed envelopes. The State will make copies for the evaluation team members.
35	RFP	3.1.2.3	10	Regarding the electronic copies, does each CD have to have the entire proposal in a PDF and a Word file? Please clarify the difference between the entire Technical Proposal (PDF) and the narrative (Word).	The proposer shall submit nine (9) CDs, each one with all of the applicable files for the proposal (PDF, MS Word, etc.). The PDF file should be the entire technical proposal, from first to last page. In addition, the CD must include a MS Word version of the narrative response to items in RFP Attachment 6.3, Sections A through C as well as attachments to the narrative response to items in RFP Attachment 6.3, Sections A through C. These attachments shall be in MS Word or in another format, preferably an MS Office program. Refer to State's Response #33 regarding contact memorandums.
36	RFP	3.2.2	11	Please clarify the statement under NOTICE: "The Proposer shall submit the Summary of Key Utilization Assumptions.....No pricing information shall be included in any part of the Technical Proposal including the Summary of Key Utilization Assumptions." Contradicting statements on where these assumptions should go.	The utilization assumptions shall be included in the Summary of Key Utilization Assumptions (see item C.72 in RFP Attachment 6.3 and RFP Attachment 6.10.), which is part of the technical proposal. The intent of RFP Section 3.2.2 is to make it clear that only utilization assumptions shall be included in the Summary of Key Utilization Assumptions. No pricing or cost information shall be included in the Summary of Key Utilization Assumptions. (See also bolded language in item C.72 of RFP Attachment 6.3.)
37	RFP	3.2	11	We anticipate that different members of the proposal evaluation team will review and evaluate specific sections of the Technical Proposal. Given the page length constraints of the RFP, and to ease the reviewer's burden, we would like to minimize the amount of redundant or repeated narrative. Within that context, however, we want to ensure that if sections of the proposal are separated and given to different reviewers, intra-proposal references will be allowed. That is, are proposers allowed to refer to other sections of the proposal, and will reviewers seek out, and take into consideration, those sections in their evaluation?	While evaluators will have a copy of the entire proposal, the proposer's response to each item shall be complete without references to other sections of the proposal (other than attachments specified by the State in the RFP or an amendment to the RFP).
38	RFP	3.2.4	12	Section 3.2.4 in the RFP specifies that proposals must contain no text smaller than 11-point font. Does this also apply to tables and text boxes contained within the text?	No. Refer to Section C of this amendment.
39	RFP	3.2.4	12	Must the proposal's pages be numbered consecutively or can each section/attachment be separately numbered?	Each section/attachment may be separately numbered. Refer to State's Response #41.
40	RFP	3.2.4	12	Is text that is part of a graphic (e.g., chart legend) subject to the 11-point font requirement?	No. Refer to Section C of this amendment.
41	RFP	3.2.4	12	Do attachments need to have page numbers?	Yes, attachments must have page numbers. Each attachment may be separately numbered. Refer to State's Response #39.

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42	RFP	3.2.4	12	Much of the information requested by the State will be best represented in a tabular or graphical format. Will the State consider changing the requirement for minimum font size to 8 point or 9 point for tables and graphics?	Yes. Refer to Section C of this amendment.
43	RFP	3.3.5.3	15	The text says that the minimum rate for the East is the data book rate adjusted to moderately well managed care levels, and the West is the data book rate adjusted to aggressively managed care levels, suggesting the adjustment for the West is bigger. However, the capitation rates in the data books show bigger adjustments for the East. What is the basis for the managed care adjustments, and is the text of the cap rate incorrect?	Please refer to the Managed Care Utilization savings discussed in the data book for East and West. The baseline utilization levels in the West are lower than the East. Therefore, less additional managed care impact is assumed.
44	RFP	3.3.8	16	Since there is no kick payment for maternity and no compensation to an MCO who may experience a disproportionate share of deliveries, will the Bureau consider a Maternity risk score adjustment and a non-Maternity risk score adjustment?	Hopkins ACGs risk profiles take maternity conditions into account and are built into the factors. No additional adjustment would be required.
45	RFP	3.3.8	16	Would the State make available any existing information regarding how the risk adjustment methodology would be implemented, including any reconciliation processes, if this information is published and available?	The Hopkins ACG system is published and information on risk modeling can be found on their website. The State will develop risk scores using a 12-month look back window. The scores will only impact the capitation rates between the contractors, with no net overall impact to the State.
46	RFP	3.3.8.1	16	Would the State be willing to eliminate the 3% change in the health status threshold? Would the State be willing to adjust the MCO's capitation payment rates every 6-months based on the change relative to the initial regional average? Given only 2% margin in the proposed capitation payment rates, the 3% health status change threshold appears to be very high.	The 3% threshold was viewed as a reasonable threshold and is currently in place in the Middle region. If the threshold is reached the entire adjustment would apply.
47	RFP	3.3.8.1	16	How will a change in the underlying health status of the population between SFY 2007 and contract period (Nov 2008 - June 2010) be handled? Will the capitation payment rates be adjusted for any significant changes?	There will be no overall adjustment to the rates for any additional health status changes.
48	RFP	3.3.8	16	This section states that after initial enrollment, the risk adjustment will be determined within 30 days. Is it then a monthly process after that?	The rates are adjusted on an annual basis.
49	RFP	4.2	18	How will the Bureau address questions from proposers raised as a result of amendments to the RFP after the designated Q&A period?	No. There was only one opportunity to ask questions about this RFP.
50	RFP	4.3	18	Are proposals from separate companies that are separately licensed legal entities but are affiliated through a common parent corporation considered to be more than one Technical Proposal?	If two companies are affiliated or have the same parent company, the companies would be considered to be the same proposer and could only submit one proposal. Refer to Section D of this amendment and State's Response #52.
51	RFP	4.3	18	May a Proposer withdraw a submitted proposal after the proposal submission deadline?	No.

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52	RFP	4.3	18	If after the proposal submission deadline but before the contract award of State contract(s), a Proposer is acquired by another entity, may the Proposer file an amendment to its proposal supplementing its data to reflect information about the new ownership?	No. The State will not allow a proposer to amend its proposal under these circumstances. Please also note that RFP Section 4.3.8 mandates that the State reject a proposal if the Cost proposal was "... not arrived at independently without collusion, consultation, communication or agreement" with another Proposer, as to any matter relating to price. The State defines a Proposer to include a corporation, and any parent, affiliates or subsidiaries. Based on past experience the State will assume that one company, in its negotiations re merger or acquisition of a second company will receive and/or exchange information with the second entity. This information would involve financial information on such items as medical loss ratios, utilization data, pay for performance plans and administrative costs. All of these factors plus others would affect the Cost proposal. Therefore, under the language of Section 4.3.8 of the RFP, if both of the entities submitted a proposal, these proposals would be rejected.
52 cont.					#52 cont. However, if only one entity submitted a proposal, there would be no collusion or communication with another Proposer and so the proposal would be accepted for evaluation.
53	RFP	4.3	18	If a Proposer is acquired by the parent corporation of another Proposer after the proposal submission Deadline but before the award of State contract(s), how will the state evaluate the two Proposers submissions so as not to violate RFP section 4.3?	It is extremely unlikely that an acquisition could begin and be completed in the time between the submission of the proposals and the award of the contract. Negotiations and discussions between the two entities would have been underway before the proposals were submitted. Therefore the analysis in States' Response #52 above would apply. The State would reject both proposals.
54	RFP	4.3	18	If two Proposers are awarded the State contract(s), and after the award the parent corporation of one of the Proposers acquires the other Proposer, may both Proposers retain the State contract(s)?	No. One Contractor, defined to include a company, its parents, affiliates and subsidiaries, shall not be allowed to manage and/or maintain ownership of more than one MCO in any one of the Grand Regions of the State. There are two exceptions to this rule: 1) a Contractor may manage a MCO in one or more of the Grand Region(s) of the State even though it also manages TennCare Select; and 2) the State may waive this rule in extraordinary circumstances (for instance if a company is in liquidation) in order to provide services to enrollees until another contractor is found. In the event that a company has more than one MCO in any one of the Grand Regions of the State, the State will determine which of the two contracts will be allowed to continue and which will be terminated. Refer to Section J of this amendment.
55	RFP	4.15	22	Certain management services are conducted for the Proposer by its parent company; does the parent company (a holding company) need to register with the State?	No, only the entity awarded the contract needs to register. A proposer who is awarded a contract must register prior to execution of the contract.
56	RFP	5.1	24	Will preference points be offered to "co-bidders" that are in the process of an acquisition, even if the acquisition is not closed by the proposal submission date or will a bidder be evaluated solely on its status as of the proposal submission date?	No, preference points will not be offered to "co-bidders" that are in the process of an acquisition. Refer to State's Response #50 and #52-54.
57	RFP	3.3.3.1	13	Reference to 3.3.4.2 is included in this section but there is no 3.3.4.2 in the document. Is this the same as Exhibit 16 in the West Region Data Book or are there other rates we need to be aware of?	The reference should be to Section 3.3.5.3. Refer to Section B of RFP Amendment #1.
58	RFP Attach 6.1	Section 1	9	Can the Bureau confirm that the Medicare deductible and coinsurance are NOT included in benefits for dually eligible members?	The Medicare deductible and coinsurance are not included in benefits for dually eligible members who are TennCare Medicaid (as opposed to TennCare Standard) enrollees. If appropriate, TennCare pays the applicable Medicare deductible and coinsurance for TennCare Medicaid enrollees who are also Medicare beneficiaries.

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59	RFP Attach 6.1	Section 1	13	Where are the current TDMHDD eligibility criteria for "State Onlys"?	See TDMHDD's "Manual for Mental Health Coverage for Uninsured Tennesseans" available on TDMHDD's website at http://www.tennessee.gov/mental/mgdcare/ManualUninsuredTennesseans.pdf
60	RFP Attach 6.1	2.1.1.2	16	If a subcontractor already maintains an approved Utilization Review license as an MBHO, do they also need to complete a PLHSO application?	If the subcontractor meets the definition of a PLHSO, as determined by TDCI, then the subcontractor will need to be licensed as a PLHSO. TCA 56-51-102(9) defines a PLHSO as "any person, corporation, partnership, or any other entity which, in return for a prepayment from a health maintenance organization or a state or federal agency, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers." A utilization review license does not substitute for a PLHSO license.
61	RFP Attach 6.1	2.1.1.2	16	Is a behavioral health organization required to have a PLHSO license if such an entity is only providing various administrative services?	Refer to State's Response #60. TCA 56-51-102(9)(C) exempts "any person who, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion thereof" from the definition of a PLHSO.
62	RFP Attach 6.1	2.1.1.2	16	Is a subcontractor required to be licensed as an HMO or PLHSO if such an entity holds less than 15% of the risk?	Refer to State's Response #60 and #61.
63	RFP Attach 6.1	2.1.1.2	16	Section 2.1.1.2 of the RFP states that TDCI may require a behavioral health subcontractor to be licensed as a prepaid limited health service organization (PLHSO). Please indicate whether or not TDCI will require a behavioral health subcontractor to be licensed as a PLHSO.	Refer to State's Response #60 and #61.
64	RFP Attach 6.1	2.4.4.3.3	20	Will children who are TennCare members and are subsequently approved for SSI be auto disenrolled and put into TennCare Select? Would the member have to request to opt-in in order to remain on our plan?	Yes, as provided in Section 2.4.4.3.3, children who are TennCare enrollees and become eligible for SSI will be auto enrolled into TennCare Select, but children may opt-out of TennCare Select and choose another MCO.
65	RFP Attach 6.1	2.4.5.3	22	If a TennCare Enrollee is with another MCO prior to start date of operations, but becomes member of our MCO as of start date of operations, are provisions of this section applicable? Would our MCO be responsible for any claims incurred prior to start date of operations in this scenario?	If a TennCare enrollee is with one MCO before enrolling within another MCO, the second MCO is only responsible for claims incurred as of the date of enrollment in the second MCO.
66	RFP Attach 6.1	2.4.6	23	Is the ABD population distinguished by a reporting characteristic on data received from the state?	The files from the State include each member's rate category (e.g., disabled age <21, Medicaid Age 65+). They do not include the member's eligibility category.
67	RFP Attach 6.1	2.4.9	24	When does the mother apply for a newborn Medicaid ID? Before or after the birth?	If the mother is Medicaid eligible at the time of the birth she must inform DHS of the child's birth, but she does not have to complete a Medicaid application for the child (newborns are automatically eligible for one year after birth when born to a woman who was eligible at the time of birth and the child continues to live with the mother). The newborn is assigned its own Medicaid ID after birth.
68	RFP Attach 6.1	2.4.9	24	Is the MCO required to send any letters to pregnant women: 3rd trimester letter regarding an unborn child application, PCP assignment, congratulatory birth letter?	No.
69	RFP Attach 6.1	2.4.7.3	24	What are the turnaround timeframe for TennCare to disenroll a member who moves out of the MCO region? This would be important since the MCO is responsible for all out of network care until the disenrollment occurs.	In general the effective date of disenrollment is on or before the first calendar day of the second month following the month that TennCare is notified that the member has moved out of the MCO's region.
70	RFP Attach 6.1	2.4.9.5	25	Will the state notify the MCO when a newborn has been enrolled with the incorrect MCO? How will the correct MCO know who the incorrect MCO was?	The State notifies the MCO that a newborn has been incorrectly assigned through the 834. There is a manual process in place that identifies the member's new MCO to the previous MCO.

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71	RFP Attach 6.1	2.4.9.5	25	What is meant by "properly documented request for reimbursement" in the statement "...the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO.?"	It means documentation of the claim(s) paid by the first MCO.
72	RFP Attach 6.1	2.6.1.2.5	29	A single case manager will not likely have expertise in both physical and behavioral health disciplines. May this be a collaborative effort between two people, or must it be one person?	Refer to Section F of this amendment.
73	RFP Attach 6.1	2.6.1.3	30	Please provide additional specific information on the covered and excluded services associated with the Newberry consent decree.	The Newberry Consent decree can be found on TennCare's website at http://www.tn.gov/tenncare/legal.html . It specifies that medically necessary home health care services shall not be denied for a variety of reasons that are specifically listed in the decree and in TennCare's medical necessity rules at 1200-13-16, available on the TennCare website at http://state.tn.us/sos/rules/1200/1200-13/1200-13-16.pdf . TennCare will provide technical assistance in this area after contract award.
74	RFP Attach 6.1	2.6	31	Pharmacy Services -- reimbursement of injectables and home infusion services-- is Contractor required to follow TennCare's PBM's formulary or does Contractor have to establish a formulary for injectables and home infusion services?	The contractor is not required to follow TennCare's PBM formulary for injectables and home infusion services. (For the majority of cases, these items would not be part of TennCare's PBM formulary.) The contractor shall establish policies for reimbursement of these services.
75	RFP Attach 6.1		33	Do transplants need to be covered if Medicare covers them, even if the requested transplant does not meet the Contractor's/Regulatory definition of experimental/investigational?	Transplants covered by Medicare are a covered benefit under TennCare. This does not negate the need to determine medical necessity on a case-by-case basis. TennCare's requirements regarding medical necessity determinations is available in rules at 1200-13-16 which can be accessed through the TennCare website at http://state.tn.us/sos/rules/1200/1200-13/1200-13-16.pdf .
76	RFP Attach 6.1	2.6.1.5	34	"Substance Abuse Benefits Limit 10 days detox, \$30,000 in medical necessary lifetime benefits age 21 and older." Explain how MCO will obtain new members previous lifetime benefits utilized for both dollars and days? What type of report, frequency, data elements and other requirement will the State be responsible for giving the MCO?	A file will be transmitted to the MCO with the information.
77	RFP Attach 6.1	2.6.1.5	34	"Substance Abuse Benefits Limit 10 days detox, \$30,000 in medical necessary lifetime benefits age 21 and older." Is the detox 10 day limit exclusive of the \$30,000 lifetime limit? If the member has reached his \$30,000 life time max for inpatient and outpatient benefits but not the 10 day limit for detox, is the MCO responsible for coverage?	The detox 10 day limit is part of the \$30,000 lifetime limit. If the member has reached the \$30,000 lifetime limit, the MCO is not responsible for any other substance abuse services, including detox, regardless of whether the member has reached the 10 day detox limit.
78	RFP Attach 6.1	2.6.1.5	34	"Substance Abuse Benefits Limit 10 days detox, \$30,000 in medical necessary lifetime benefits age 21 and older." Is the \$30,000 limit based upon amount reimbursed?	Yes. The \$30,000 limit is based on the amount reimbursed.

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79	RFP Attach 6.1	2.7.1	38	Please clarify - must the contractor review ER claims prepayment, or can it be done through post pay reporting and utilization reporting? This could produce additional administrative savings.	This question is not clear. To the extent the contractor denies a claim, it needs a valid reason for doing so prior to making the determination to deny - this would necessitate a prepayment review of some sort. Review of approved claims could certainly occur post pay as a part of a non-claim specific utilization monitoring process. TennCare would strongly discourage a contractor from approving all ED claims on the front end and then relying upon routine use of a post payment review of individual claims followed by recoupment of those deemed non-emergent as a method of managing ED utilization.
80	RFP Attach 6.1	2.7.2.2.2	40	Is the MCO prohibited from contracting with a Behavioral Health inpatient facility that does not accept involuntary commitments?	Yes.
81	RFP Attach 6.1 RFP Attach 6.12 RFP Attach 6.13	2.7.2.8.2	43 18	Behavioral Health Crisis Respite and Crisis Stabilization Services are a contract requirement set forth in the Pro Forma Contract. It appears that there is a need for development of infrastructure and there will be a need for service dollars to be paid to providers to make this service financially viable. Does the State plan to make available to providers the infrastructure dollars for development of these services? Will the State subsidize providers with service dollars to make crisis respite and crisis stabilization services financially viable since the data book reflects limited service dollars?	The State has not finalized the decision to make infrastructure funds available for these services. If infrastructure services are funded the State would contract for service capacity for uninsured Tennesseans.
82	RFP Attach 6.1	2.7.4.2	46	Who may grant presumptive eligibility? Will these women be identified on the eligibility file?	All local health departments and Federally Qualified Health Centers (FQHCs) may authorize presumptive eligibility. Yes, pregnant women with presumptive eligibility are identified on the 834.
83	RFP Attach 6.1	2.7.5.1.7 2.7.5.4.8	48 53	Please clarify: if no referral is required for these services, what is the context for the prior authorization referred to by these sections?	The contractor may not require prior authorization for periodic or interperiodic EPSDT screens conducted by PCPs. The contractor may place prior authorization requirements on other services for children; however, the contractor must provide any medically necessary covered service even if it is ordered by a provider that was not authorized by the contractor to treat the child. For example, if a child goes to see a non-contract specialist without seeking advance approval from the contractor, and the specialist orders a covered diagnostic test for the child that must be prior authorized, the contractor must evaluate the medical necessity of the diagnostic test and pay for it if it is medically necessary regardless of the fact it was ordered by a provider that had not received authorization to treat the child. The contractor may not deny the diagnostic test on the sole basis that the test was ordered by a provider that had not been authorized to treat the child.
84	RFP Attach 6.1	2.7.5.4.7	52	Please clarify acceptable providers for primary site lead inspection services.	Primary site lead inspection must be conducted by Tennessee certified lead paint inspectors. Contact the Tennessee Department of Environment and Conservation for additional information.
85	RFP Attach 6.1	2.7.5.4.7.3	52	"MCO responsible for lead inspections." Does the State have a list of acceptable or licensed "lead inspectors" who are approved by the State to provide this service? Can the State provide that list to the MCO's?	Refer to State's Response #84. A list of Tennessee certified lead paint inspectors and additional information is available on the Tennessee Department of Environment and Conservation's website at http://state.tn.us/environment/swm/leadpaint/listprof.shtml .
86	RFP Attach 6.1	2.7.5.4.8	54	Can the state provide guidance on Private Duty Nursing requirements- are there specific guidelines for this service? Section 1905 (a) does not provide specific guidance.	See TennCare rules at 1200-13-13-.01 (81) and 1200-13-13-.04 (30). The State will provide technical assistance on this topic after contract award.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
87	RFP Attach 6.1	2.7.5.4.8 2.8.2 2.8.3	57	Care coordination, case management and disease management require member stratification. Stratification is optimized by the amount of historical data available to analyze (hopefully two years). Will MCOs receive all utilization data on members for all services including BH, SA and Rx? If so, for what is the timeframe of the data that would be provided? When would that data be provided? Could historical utilization data be provided with redacted member data prior to submission of the RFP?	After contract award and prior to the start date of operations, the contractors will receive utilization information on members for all services. Refer to State's Response #20. This information will not be provided prior to the proposal submission date.
88	RFP Attach 6.1	2.7.5.4.8 2.8.2 2.8.3	57	Given that care coordination, case management and disease management require member stratification, could TennCare provide a current TN Care eligibility file that includes for each Member the following data: a unique record ID, Zip + 4 address values, DOB or age at December 31, 2007, gender, and TennCare eligibility classification? This file would not require any member specific data.	The State has sent eligibility extract files with selected fields to all proposers that submitted a Notice of Intent to Propose.
89	RFP Attach 6.1	2.7.5.4.8	57	Can the state provide guidance on Personal Care Services requirements- are there specific guidelines for this service? Section 1905 (a) does not provide specific guidance.	See TennCare rules at 1200-13-13-.01 (74). The State will provide technical assistance on this topic after contract award.
90	RFP Attach 6.1	2.8	61	Will the MCO be obtaining historical claims data for each new member? What type of report, frequency, data elements and other information will the MCO receive?	Yes. Refer to State's Response #87.
91	RFP Attach 6.1	2.6.1.4.1	67	Are denied services to be taken into account when tracking benefit usage? The present inpatient requirement requires the MCO to track services recorded in their system, does TennCare intend for that tracking process to stay in place or should MCOs use the 271U data as the threshold determination?	No, denied services shall not be taken into account when tracking benefit utilization. Yes, each MCO shall count claims processed by that MCO and report that information to TennCare. The MCO should use the 271U to get the count from other MCOs in order to get the most current total utilization for a member.
92	RFP Attach 6.1	2.9.5	68	Given the need to insure that services are continued and appropriate treatment plans developed, will the successful bidders receive historical utilization information for their SPMI and SED populations? If so, for what timeframe?	Yes. A file with this information will be provided to the contractors after contract award.
93	RFP Attach 6.1	2.9.4.3	68	Requirement 2.9.4.3 states that members who have reached the service threshold for inpatient hospital services shall be enrolled [emphasis added] in either MCO case management or a disease management program. Requirement 2.9.4.5 says that "member participation [in MCO case management] shall be voluntary." How should bidders understand 2.9.4.3 in light of 2.9.4.5?	If the member does not have a condition covered by one of the disease management program, the contractor shall use its best efforts to encourage the member to enroll in MCO case management.
94	RFP Attach 6.1	2.9.5.3.2	69	Where can we find TennCare approved tools for screening members for Behavioral Health needs in a PCP or other setting?	The State will approve screening tools on a case-by-case basis.
95	RFP Attach 6.1	2.9.6.1.2	70	Where can we find TennCare approved tools for mental health providers to screen members for substance abuse problems? Will the Bureau consider approving additional tools if appropriate?	The State will provide a list of approved screening tools prior to the start date of operations. In addition to the State approved tools, the State will consider additional tools if appropriate.
96	RFP Attach 6.1	2.9.6.1.3	70	Where can we find TennCare approved tools for substance abuse providers to screen members for mental health problems? Will the Bureau consider approving additional tools if appropriate?	The State will provide a list of approved screening tools prior to the start date of operations. In addition to the State approved tools, the State will consider additional tools if appropriate.
97	RFP Attach 6.1	2.9.6.1.2	70	Under 2.9.6.1.2, what tools are being referred to?	Refer to State's Response #96.
98	RFP Attach 6.1	2.9.7	71	"Analyzing prescription drugs reports provided by PBM." How will the MCO obtain PBM member information? What type of report, frequency, data elements and other requirement will the PBM be responsible for giving the MCO?	TennCare will provide the MCO with pharmacy claims data for its members in a proprietary format on a weekly basis based on data received from the PBM.

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99	RFP Attach 6.1	2.11.3.3.1 2.30.7.1	84	The RFP references a monthly Provider Enrollment file; however, in keeping with dependencies for encounter (weekly) and 834IB (daily) data validation against the submitted providers and current submission requirements in the Middle Region should this requirement be a weekly submission?	The Provider Enrollment file is a monthly submission. However, the State may request that the file be submitted more frequently.
100	RFP Attach 6.1	2.11.7.1.2	87	The RFP requires processing of completed credentialing applications within 30 days of receipt. Are there any provider types that are exempt from this standard? (For example, chiropractors or other specialties.) What sanctions apply to failure to meet this standard?	No provider types are exempt from the requirement to process credentialing applications within 30 days of receipt of a completed application. See item B.20 in Section 4.20.2.2.7 of RFP Attachment 6.1 for the liquidated damages associated with failure to meet this requirement.
101	RFP Attach 6.1	2.11.7.2	87	Please clarify this requirement by giving an example of a non-contracted provider that would need to be credentialed. The way "independent relationship" is defined is more similar to a participating provider, not a non-contract provider.	For example, if the contractor directs members to a particular hospital for transplants but uses single case agreements instead of a provider agreement, the contractor would have to credential that hospital. The intent of this requirement is to ensure that all providers with which the contractor has an independent relationship, regardless of whether there is a provider agreement in place, is credentialed by the contractor.
102	RFP Attach 6.1	2.11.7.2	87	Are there parameters for determining a non-contracted provider?	Refer to NCQA's Standards and Guidelines for the Accreditation of MCOs. Refer also to State's Response #101.
103	RFP Attach 6.1	2.11.7.2.1	87	"Credentialing Non-contract Providers.credentialing of licensed independent providers with whom you do not have a contract with." Since an independent relationship exists when MCO directs a member to a specific provider or group is the MCO responsible for credentialing providers when the patient selects and utilizes an out of network providers?	It would depend on other factors not provided in the question. If there is an independent relationship between the contractor and the provider, the contractor shall credential the provider. Refer to State's Response #102.
104	RFP Attach 6.1	2.11.7.2.1	87	"Credentialing Non-contract Providers.credentialing of licensed independent providers with whom you do not have a contract with." Since an independent relationship exists when MCO directs a member to a specific provider or group is the MCO responsible for credentialing providers when the patient is directed to a facility for treatment when they are out of State?	It would depend on other factors not provided in the question. If there is an independent relationship between the contractor and the provider, the contractor shall credential the provider. Refer to State's Response #102.
105	RFP Attach 6.1	2.11.8.1.5	89	Is this member notification requirement one time only? If the notification is more than one time, what is the frequency for the notice?	In general this notice is one time only. However, if the deficiency continues, TennCare may require the contractor to issue additional notices.
106	RFP Attach 6.1	2.11.8.2	89	If Contractor's provider contracts allow for Contractor to terminate provider immediately for loss of license, suspension from Medicaid/Medicare, or placing member's life in danger, etc., is 30 day notice to TennCare still required? It would seem that delaying the termination date to accommodate notice to TennCare would be problematic in most instances where immediate termination is warranted.	If the provider is a hospital, the contractor should notify TennCare as soon it is aware that the hospital may be losing its licensure, Medicare certification, etc. If the contractor only becomes aware when the situation would be the basis for immediate termination, the contractor shall immediately notify TennCare to discuss the termination.
107	RFP Attach 6.1	2.12	90	Section 2.12.3 states that the "Contractor shall revise provider agreements as directed by Ten care." Please confirm that such revisions would not exceed the boundaries of applicable regulation and State/Federal law.	The State would require revisions to the provider agreement to ensure that the provider agreement complies with applicable requirements, including the Agreement, federal/state regulations, and federal/state law.
108	RFP Attach 6.1		97	Will the state support payment of non-participating providers at 80% of the established Medicaid fee schedule, in order to encourage providers to participate in MCO networks?	Refer to TennCare rule 1200-13-13-.08 for TennCare's policy on payment of non-contract providers. TennCare has no plans to change the policy regarding payment of non-contract providers for non-emergency services. However, TennCare has submitted a Medicaid state plan amendment to reimburse medically necessary covered emergency services provided by non-contract hospitals at 74% of the 2006 Medicare rate for those services.
109	RFP Attach 6.1	2.13.4.1	98	Section 2.13.4.1 (page 132 of 1054) states that the contractor will "reimburse crisis mobile teams for their intervention services on a monthly basis at a rate to be determined and set by the State". What guidance can be given regarding the amount that will be passed through to the providers (PMPM)?	The crisis portion of the Grant PMPMs listed in the data book are as follows: East FY06 - \$1.04 FY07 - \$1.03 and West FY06 - \$0.78 FY07 - \$0.88.

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110	RFP Attach 6.1	2.13.7	100	Does TN allow for ED Prudent Lay Person (PLP) review of emergency room medical records to ensure the claim was processed correctly ?	The State is not clear on what the proposer is asking. Refer to State's Response #79.
111	RFP Attach 6.1	2.9.7	105	Please provide additional detail regarding the following: availability (timeliness and completeness) of pharmacy data received from the state and/or PBM, and the format in which the data will be delivered.	Refer to State's Response #98.
112	RFP Attach 6.1	2.15.6	111	What is the rationale for not allowing New Health Plan accreditation from NCQA? NCQA typically reviews 2-3 cycles of HEDIS and requires, at a minimum, 18 months of data for full health plan accreditation. This will make the required timeframe difficult to achieve.	TennCare is aware of the NCQA timeframes for accreditation and will determine the deadlines for the milestones in Section 2.15.6 of RFP Attachment 6.1 in accordance with NCQA's requirements.
113	RFP Attach 6.1	2.16.1.3	113	Under 2.16.1.3, "offers of gifts or material or financial gain as incentives to enroll" is listed as a prohibited activity. Is the MCO allowed to give away items such as pens, stress balls, children's sippy cups, etc at Health Education seminars/events? Is there a specific dollar limit imposed?	Yes, the MCO may give away these types of items if prior approved in writing by TennCare. There is no specific dollar limit for these items.
114	RFP Attach 6.1	2.16.1.4	113	Does 2.16.1.4 (Prohibition of compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled) apply to reps and management as well?	Yes. Section 2.16.1.4 of RFP Attachment 6.1 applies to marketing reps and management.
115	RFP Attach 6.1	2.16.2	113	Under 2.16.2 requires written approval by TennCare for all health education and outreach activities. We respectfully request the ability to submit a weekly calendar and have denials only rather than waiting for specific event written approval. This will allow us to respond on shorter notice to the various community organizations who request our support at events.	The State will work with the contractors on this after contract award.
116	RFP Attach 6.1	2.17.1.3	114	The contract identifies that the Bureau has 15 calendar days to review and approve/deny materials. Is this timeline accurate? Currently in the Middle Region, this timeline is 15 business days in practice.	The Bureau does not follow a 15 business day turnaround for member material. If the 15th calendar day falls on a weekend or state holiday, the Bureau rolls the due date forward to the next business day. This is the same practice that the Bureau follows for receipt of deliverables due on a calendar day basis from MCOs.
117	RFP Attach 6.1	2.17.2.3	115	Can the Bureau confirm that any non-discrimination assurance language that is currently acceptable for the Middle Region is also acceptable for the East and West Region contract?	Yes. The non-discrimination language used by MCOs should be consistent throughout the TennCare program. Language previously approved by the Bureau for use in the Middle Region will be acceptable for the East and West regions.
118	RFP Attach 6.1	2.17.2.5	115	With regard to member materials, does the translation requirement apply to groups comprising 5% of the statewide TennCare population or the regional TennCare population?	This is determined according to TennCare policy. Currently, the translation requirement applies to groups comprising 5% of the statewide TennCare population.
119	RFP Attach 6.1	2.17.2.3	115	Regarding 2.17.2.3, the State indicates that "materials shall be printed with the assurance of non-discrimination." Beyond the Contractor's practices of non-discrimination, is the State requiring that all printed materials include a printed statement of non-discriminatory practice?	Yes. All printed member materials shall include a printed statement of non-discrimination. Note that pre-printed materials from outside the MCO (e.g., American Diabetes Association) must be prior approved in writing by the Bureau and are to be sent to members with a cover letter that includes the printed assurance of non-discrimination.
120	RFP Attach 6.1	2.17.2.1	115	May member materials be worded at a lower than 6th grade reading level?	As provided in Section 2.17.2 of RFP Attachment 6.1, member materials may be worded below the 6th grade reading level if approved by TennCare.
121	RFP Attach 6.1	2.17.4.2	116	In the event that there are revisions to the member handbook, the contract requires that the health plan distribute a new and revised handbook to all members immediately. Can the Bureau confirm that health plans can comply with this requirement by distributing inserts of material revisions rather than reissuing a new handbook?	The contractor must reissue its member handbook annually. If approved by TennCare, changes made before the annual reissuance may be distributed as inserts.

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122	RFP Attach 6.1	2.17.6.10	121	What are the eligibility requirements for the words "Medicaid" or "Standard" that need to be on the identification cards?	TennCare Medicaid is for persons who are eligible for Medicaid under the State Plan as categorically or medically needy. TennCare Standard is for persons who are not Medicaid eligible but who have been determined to meet the State's criteria as being either "uninsured" or "uninsurable". For additional information, see TennCare's website at http://tennessee.gov/tenncare/mem-categories.html .
123	RFP Attach 6.1	2.17.5.4	121	Regarding 2.17.5.4, please provide direction as to where the "reporting schedules as described in Section 4-8 of this Agreement" are located. Section 4.8 of the pro forma Agreement is under the heading "Technical Assistance" and does not appear relevant to reporting schedules.	The correct reference is Section 4.20. Refer to Section H of this amendment.
124	RFP Attach 6.1	2.18.1.5	123	This section of the RFP states that the member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members. Does the member services information line need to be located in Tennessee during regular business hours (8 am to 5 pm, M-F)? Does the member services information line need to be located in Tennessee after hours and on weekends and holidays?	As provided in Section 2.29.1.8 of RFP Attachment 6.1, unless otherwise authorized by TennCare, the contractor's member services shall be located in the State of Tennessee. Note that although TennCare would prefer member services to be located in Tennessee, TennCare will consider requests for member services to be located outside of Tennessee.
125	RFP Attach 6.1	2.18	124	What is the intent of the language, "Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting."? After normal business hours, those types of settings maybe closed and unavailable to make appointments.	The intent is to assure the ED doctor that appropriate follow-up will be provided and ensure that the MCO assists with scheduling an appointment as soon as possible.
126	RFP Attach 6.1	2.19.2	128	Under 2.19.2, the MCO is required to educate 'staff' on importance of appeals. What is the definition of 'staff' for this requirement?	Staff includes, but is not limited to, all MCO employees and contractors that interact with members or are involved in utilization management decisions.
127	RFP Attach 6.1	2.19.2	129	Are there statistics available from the TennCare Bureau as to the number of appeals that result in an overturn whereby the MCO is directed to cover the requested service by the TSU?	During calendar year 2007, approximately 5% of MCC (which includes MCOs, BHOs, the PBM, and the DBM) decisions were overturned. Approximately 3% were overturned by TennCare and another 2% were overturned by an Administrative Law Judge during hearing.
128	RFP Attach 6.1	2.20.3.3	133	This section contains a reference to a "...Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG." We are not aware of a Model Compliance Plan being issued by DHHS for either Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans. However, we are familiar with the "Compliance Program Guidance for Medicare+Choice Organizations" issued in 1999. Is that the document the Bureau of TennCare is referring to in this section? If not, please clarify.	Yes.
129	RFP Attach 6.1	2.21.4.8	135	Is the submission of TPL data to a provider on request or required with each denial?	Data should be provided to support each denied claim.
130	RFP Attach 6.1	2.22.4	143	56-32-226 references 56-32-107, which references 56-32-109. Are the prompt payment provisions of 56-32-109, including the interest requirement in (b)(4) applicable?	Question is unclear. Section 56-32-226 does not reference 56-32-107, and Sections 56-32-101 through 109 have been repealed. Refer to State's Response #131.
131	RFP Attach 6.1	2.22.4	144	Does interest apply? TCA 56-32-226 is listed as a requirement in the contract. It does not cross refer 56-7-109 documenting interest penalties.	No. TCA 56-7-109 does not apply to an HMO's TennCare line of business.

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132	RFP Attach 6.1	2.22.8.2	146	Is a member to receive an EOB for only services with a member responsibility amount or all non-sensitive services? There is a specification to exclude certain sensitive services. Please define what constitutes a sensitive service.	The contractor is required to provide EOBs to a sample of members as provided in Section 2.22.8.4 of RFP Attachment 6.1. However, as provided in Section 2.22.8.2 of RFP Attachment 6.1, the contractor shall omit claims for sensitive services. Sensitive services are identified using ICD-9 codes. The list of codes will be provided to MCOs after contract award.
133	RFP Attach 6.1	2.22.13.1	147	Is there a website that lists Tennessee Medicaid ineligible providers? Will MCOs have access to the data on the website?	TennCare sends MCOs a list of excluded providers.
134	RFP Attach 6.1	2.22.13	148	"Contractor shall not pay any claim on payment hold under the authority of TENNCARE." How will TENNCARE communicate providers who are hold for reimbursement? What type of report, frequency, data elements and other information will the MCO receive?	TennCare will send MCOs a list of providers who are on payment hold.
135	RFP Attach 6.1	2.23.3.6	151	Can TennCare provide clarification on how this will be monitored or validated? Should MCO apply such rules to addresses received from TennCare in the 834 eligibility transaction?	Addresses should meet 834 compliancy standards for both inbound and outbound 834 processing.
136	RFP Attach 6.1	2.23.4.1	152	ACS won a five year contract to manage the management information system for Tennessee's Medicaid program. Will ACS manage on their MMIS and under their data interfaces or will they manage on the TennCare MMIS with existing data interfaces? What is the timing of the implementation with ACS and timing related to the planned MCO implementations for East and West TN? Will HIPAA standard x12 interfaces be implemented?	ACS was awarded the TennCare MMIS Facilities Manager (FM) contract. This is a takeover of the current contract currently planned for January 2009. The FM contractor will continue to manage the TennCare MMIS on the existing state owned infrastructure with the existing data interfaces.
137	RFP Attach 6.1	2.23.5.4	154	Can TennCare provide clarification or provide an example of the requirement in this section?	An MCO that operates multiple information systems to perform various functions (e.g. claims management, MCO case management, service authorization management) must be able to uniquely identify a TennCare enrollee across all of these systems using a common index or other data management vehicle.
138	RFP Attach 6.1	2.23.5.2	154	When it states that the contractor shall update its eligibility/enrollment databases within 24 hours of receipt of file do you mean 24 business hours or actual hours? If actual hours, are weekends included in this requirement?	Actual hours, including weekends and holidays.
139	RFP Attach 6.1	2.23.6.1.2	154	Will all of the IT staff supporting the TennCare systems be granted global access to the system or will we need to get approval for each individual?	The requirement is for global access to all (system) functions to be restricted to specified staff jointly agreed to by TennCare and the contractor. The underlying goal is to ensure that access to certain system functions is managed/restricted based on a system user's role within the organization.
140	RFP Attach 6.1	2.23.6.5	155	Can TennCare provide detail on the intent of this requirement and define 'finalized' as used in this context?	This is a requirement that directly impacts the auditability and validity of data that the MCOs shall submit to the Bureau. Once records are deemed "final" the MCO's systems shall prevent their alteration. The MCO shall be able to recreate the transaction as originally submitted to TennCare. A related requirement (Section 2.23.6.4 of RFP Attachment 6.1) is that "audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded."
141	RFP Attach 6.1	2.23.10.4	160	Are system changes which are subject to TENNCARE prior written approval only those referenced in section 2.23.7.1?	The Bureau requires notification in advance of any system changes that directly and significantly impact the processes that support the contract requirements. Such changes may require prior approval and may require testing with TennCare before implementation.

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142	RFP Attach 6.1	2.23.11.2	160	Can the State clarify what type and level of access it expects for TennCare personnel to access the PHP information systems. PHP does not routinely provide access to its core transaction production systems for ad hoc reporting purposes other than specific auditing because such access can destabilize and negatively affect system performance for daily processing activities. PHP is willing to grant access to our Data Warehouse system for routine reporting requests upon the completion of suitable training by TennCare staff.	The Bureau would want access to systems that the MCO uses to analyze data on TennCare enrollees and to run management reports – it could be a data warehouse, a decision support system, etc. The Bureau would not want to access production systems. The Bureau would only want “read-only” or “inquiry only” access to the systems they would have access to.
143	RFP Attach 6.1	2.24.4.2.3.2	164	Would the requirements regarding access to records set forth herein also apply to documents mailed to the members by Proposer? For example, should all mailings to members 16 and over be addressed to the member directly, and not to the parent/guardian? Conversely, should all mailings to members younger than 16 be mailed to the parent/guardian? Are there exceptions for certain sensitive issues such as STDs, mental health, pregnancy?	These provisions do not require that general mailings be sent directly to minors nor prohibit general mailings from being sent to parents/guardians. However, if a member requests that information protected by confidentiality requirements be sent directly to him/her and not to his/her parent/guardian, the MCO/provider must comply with that request.
144	RFP Attach 6.1	2.29.1	176	Many of the required staff positions identify that the individual must be dedicated to the TennCare program. Can the personnel be dedicated to the Program as a whole, over multiple TennCare contracts, or must they be dedicated to only one Regional Contract?	Yes, the personnel may be dedicated to the TennCare program as a whole (not each region).
145	RFP Attach 6.1	2.29.1.3.4	176	Given the limited availability of psychiatrists, can the psychiatrist FTE requirement be fulfilled by a combination of part-time contracted staff which would make up the equivalent of one FTE?	No. The requirement in Section 2.29.1.3.4 regarding a full-time psychiatrist may not be fulfilled by a combination of part-time contracted staff. It must be a single, full-time person, preferably employed by the MCO (as opposed to contracted staff).
146	RFP Attach 6.1	2.29.1.8	179	Are services for after hours crisis handling and nurse line support included in the definition of member services or can these services be staffed by personnel and facilities that are out of state?	The nurse triage/nurse advice line is included in the definition of member services. As provided in Section 2.29.1.8 of RFP Attachment 6.1, TennCare may authorize exceptions to the requirements for in-state staff. Refer to State's Response #124.
147	RFP Attach 6.1	2.30.6.1.1	183	This section requires the plan to submit an MCO Case Management Services Report. What is the frequency of this report?	The MCO Case Management Services Report is submitted once initially by the date specified by TennCare and thereafter the contractor shall provide quarterly updates.
148	RFP Attach 6.1	2.31	194	Behavioral Health providers are sharing their discussion that is occurring with the State to move the responsibility for State Onlys and Judicials to TDMHDD including the applicable service dollars currently included in this RFP? Is it the plan of the State to remove the State Onlys and Judicials from the TennCare contract held by the MCOs? If so, what would be the timeframe for removal?	While the State has discussed moving the responsibility for State Onlys and Judicials to TDMHDD, at this time it is expected that the MCOs will have the responsibility for State Onlys and Judicials as specified in RFP Attachment 6.1 (for behavioral health services only).
149	RFP Attach 6.1	3.9	201	The section on withholding (3.9) states “the amount due for the first monthly payment, and for each month thereafter, calculated pursuant to section 3.6 shall be reduced by the appropriate cash flow withhold % amount and set aside for distribution to the CONTRACTOR in the next regular monthly payment, unless retained as provided below.” Will this amount be deducted at the member level or in one amount from the total remit?	The amount is deducted in one amount from the total remit.
150	RFP Attach 6.1	3.4.4	202	How will renewal rates be calculated? How will the inflation factor be determined, given there will not be credible experience data available to calculate FY2011 capitation rates?	Additional fee for service data will be combined with the managed care encounter data to develop an appropriate rate.
151	RFP Attach 6.1	3.11	203	Section 3.12 – will the HMO payment tax be paid by WellCare HMO in a separate check, or will it be withheld from the payment received from Tenn. If it is withheld, will it be at the member level or in a gross amount?	The MCO shall pay the premium tax to TDCI. It will not be withheld from the payment received from TennCare.
152	RFP Attach 6.1	3.7.1.4	204	Can you please give an example of how the subsequent retroactive adjustments would be made beyond the initial 12 months?	For example, a TennCare enrollee may become eligible for SSI with an eligibility start date going back three years.
153	RFP Attach 6.1	3.10.3.1 3.10.3.2	207	Does the State have baseline measures for the two HEDIS categories (Antidepressant Medication Management and Follow-up Care for Children Prescribed ADHD Medication)?	No.

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154	RFP Attach 6.1	3.12	209	Section 2.1.1.2 of the Pro Forma contract states that behavioral health subcontractors accepting risk under the contract may be required to be licensed as a PLHSO. Per TCA 56-51-152, an entity licensed as a PLHSO is subject to a 2% Premium Tax. If an MCO chooses to delegate risk to a subcontract, and the subcontractor is subject to paying a premium tax, will TennCare adjust the calculation of Premium Tax in the rates to account for two or more parties paying tax on the same revenue? If not, will the MCO be allowed to net out the subcontractors risk premium from its calculation of premium tax due?	As provided in TCA 56-51-152, premiums received by PLHSOs pursuant to subcontracts with TennCare MCOs are exempt from the premium tax.
155	RFP Attach 6.1	3.13.1.2 3.13.2	209	3. Contract item 3.13.1.2, page 209 and Contract item 3.13.2, pages 209 and 210 - discuss total compensation. Taken together, these clauses seem to suggest that the plan bears the risk for increases in overall enrollment and for changes in enrollment mix to higher cost categories. Can the language be change to explicitly state that the total enrollment and the enrollment mix will be accommodated through changes in total compensation.	Refer to Section I of this amendment.
156	RFP Attach 6.1	4.4.7.2.8	217	What is the timeline for TennCare approval of a termination plan?	TennCare will approve the plan as soon as practical.
157	RFP Attach 6.1	4.6	218	Please define "Technical Specifications".	This is standard state contract language. For this RFP it refers to Section 2 of RFP Attachment 6.1.
158	RFP Attach 6.1	2.6.7.3	249	Attachment II indicates the member co-payments are different based upon the member's poverty level. How will the poverty information be supplied to the MCO? Is the poverty level a field on the 834?	Information on each member's co-payment obligation, if any, is included on the 834.
159	RFP Attach 6.1	2.6.7.3	249	Attachment II indicates the member co-payments are different based upon the member's poverty level. Does cost sharing apply to all members, including children in State custody and duals?	Non-pharmacy co-payments only apply to TennCare Standard enrollees.
160	RFP Attach 6.1	2.6.7.3	249	Attachment II indicates the member co-payments are different based upon the member's poverty level. Does cost sharing apply to members when seen in a FQHC?	Members who are required to make co-payments are responsible for payment of a co-payment for non-preventive services from an FQHC.
161	RFP Attach 6.1	2.6.7.3	249	For Duals, is the MCO responsible for reimbursement of Medicare cost sharing for member's Medicare deductible, co-insurance or co-pay?	Refer to State's Response #58.
162	RFP Attach 6.1	Attach III	251	Please define how "waiting times" are calculated (e.g., from patient arrival time, from appointment time). And, would the State consider adding language that the waiting times shall not routinely exceed 45 minutes when the member arrives at or before the scheduled appointment time.	Waiting times are calculated from appointment time.
163	RFP Attach 6.1	Attach III	251	Regarding subsection (e), Documentation/Tracking requirements, please clarify what "special term and condition 4" is.	This refers to a term and condition for TennCare's 1115 waiver that requires TennCare to conduct annual enrollee surveys.
164	RFP Attach 6.1	Attach III	251	There are several references to "community standards" in this attachment. As these standards are used in evaluating network adequacy, can the Bureau identify where the community standards referenced in this section be found?	Where access time/travel exceeds standards outlined in RFP Attachment 6.1, the MCO must demonstrate access for their members (by provider type) to providers that does not exceed time/travel distances for non-TennCare patients experience in a given community for a particular provider type.
165	RFP Attach 6.1	Attach VII	263	Regarding the Performance Measures noted in 7(a) and 7(b), will the State waive the penalty upon credible evidence that the Contractor has made its best efforts to secure provider contracts?	The State has discretion regarding the imposition of liquidated damages; however, TennCare cannot enroll members until the minimum access standards are met.

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166	RFP Attach 6.1	Attach VII	264	The benchmarks for the provider network file are based on a percentage of enrollees who have access to the identified providers/services. Can the Bureau provide a file of addresses for plans to utilize in completing this analysis, to include street address, ZIP, gender and age?	Refer to State's Response #88.
167	RFP Attach 6.1	Attach VII	269	The word freestanding is used in the benchmark wording but not used in the definition. Please clarify the type of IMD exclusion facility.	An IMD exclusion facility is a facility that is an IMD as defined in 42 CFR 435.1009. In general, IMDs are "freestanding" facilities as opposed to psychiatric units of general acute care hospitals.
168	RFP Attach 6.1	Attach VII, Perf Msres 7(a) and 7(b)	269	These performance standards include access standards be met for hospitals and psychiatric inpatient hospital services. As there are no mileage standards in the pro forma for these services, but rather travel times as stipulated in in Attachment III of the pro forma, will the state establish an acceptable community standard in areas where no providers exist for a required service?	No. Refer to State's Response #164.
169	RFP Attach 6.1 RFP Attach 6.3	Attach VII, Perf Msre 16 C.59	270 40 66	Performance Measure 15 requires the Contractor to decrease inpatient utilization in non IMD or IMD exclusion facilities. RFP response C.59 asks the Bidder to describe their plans for developing non-IMD inpatient services (as well as community based alternatives to inpatient services). The inpatient utilization performance measure and the RFP response for inpatient development appear to be in conflict. Please clarify the State's intent for inpatient behavioral health utilization.	The State expects that community alternatives to inpatient hospital will be developed and used when clinically appropriate. When hospitalization is necessary, the State would prefer, in order of preference, that contractors use psychiatric units of general hospitals, private IMDs, and RMHIs (public IMDs).
170	RFP Attach 6.1	Attach XI, A.4.3.1.1	347	Can we use alternative methods of ambulatory transportation in addition to multi-passenger van, such taxi cabs, sedans, and volunteer drivers?	The list of methods was not meant to be exclusive. Additional methods of transportation may be used, as prior approved in writing by TennCare.
171	RFP Attach 6.1	Attach XI, A.4.3.1.1	347	Please define "invalid vehicle." Is it the same thing as a "stretcher van?"	Invalid vehicle is similar to the term "stretcher van" used in other states. Refer to the rules of the Tennessee Department of Health, Bureau of Health Insurance Licensure and Regulation, Division of Emergency Medical Services, Chapter 1200-12-1 at http://www.state.tn.us/sos/rules/1200/1200-12/1200-12.htm .
172	RFP Attach 6.1	Attach XI, A.13.3.1	362	This section refers to the inclusion of provisions related to payment for cancellations, no-shows escorts and adults accompanying members under age eighteen. Do the dollars and units represented in the data book include cancellations, no-shows, escorts and adults accompanying members under age eighteen?	The data books (RFP Attachment 6.14 and 6.15) contain all the services that were paid by TennCare in the applicable region.
173	RFP Attach 6.1	General	NA	Must pharmacy claims data need to be included in any reports (e.g. HEDIS)?	The MCO will need pharmacy data in order to perform some HEDIS measure calculations. This data will be supplied by the State as outlined in Section 2.9.7 of RFP Attachment 6.1.
174	RFP Attach 6.1		NA	Will the successful MCOs be required to meet all of the service requirements currently in place through the BHO contract? If not what are the differences? If, yes what are the additional requirements not contained in this RFP?	The MCO will be required to meet all of the requirements in the contract, which includes many of the requirements of the current BHO contracts as well as requirements outside of the contract, such as TDMHDD's rules and regulations (see, e.g., Section 2.7.2.1.2 of the contract).
175	RFP Attach 6.3	A.2	2	If the entity under which the proposer plans to do business is not yet operational, is it acceptable to provide these references for the proposer's parent company instead?	Yes.
176	RFP Attach 6.3	A.2	2	Vendor credit references: If an affiliated entity of the proposer is paying entity for the family of companies, would the vendor reference for the paying entity meet the requirements of the RFP? Certificate of Insurance: Do coverage requirements refer to general liability or errors and omissions coverage? Letter of Commitment: Please confirm that a general line of credit would need to be secured for the proposing entity only.	If an affiliated entity of the proposer is the paying entity for the family of companies, then a bank reference for the paying entity would meet the requirement of item A.2 in RFP Attachment 6.3. The coverage requirements for the certificate of insurance refer to general liability. The general line of credit would need to be secured for the proposing entity only.

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177	RFP Attach 6.3	A.3	2	This question references RFP Attachment 6.1, Section 4.3.9, which seems incorrect. Please provide the correct Attachment 6.1 reference.	This is an accurate reference. The intent is to ensure that no proposer has a conflict of interest as defined in Section 4.3.9 of the RFP.
178	RFP Attach 6.3	A.3	2	This question references section 4.3.9. In the Pro Forma contract, section 4.19 deals with Conflict of Interest language. Please confirm whether this reference should be 4.19?	Refer to State's Response #177.
179	RFP Attach 6.3	A.4	2	Do we need to send a letter of intent to TDCI for a material modification to perform for only the East Grand Region rather than for the entire state?	If the proposer is currently licensed as an HMO to provide services to TennCare enrollees in the East Grand Region and will submit a proposal to serve the East Grand Region (and not the West Grand Region), the proposer shall submit a letter to TDCI expressing its intent to file for a material modification to provide services pursuant to this RFP in the East Grand Region. If the same proposer were to submit a proposal to serve both the East and West regions, it would reference both regions in its letter to TDCI (not submit separate letters for each region).
180	RFP Attach 6.3	A.5	3	Independently audited financial statements are prepared only for the proposer's parent company and the parent company's statutory entities. While the parent company's audited and internally prepared financial statements are prepared under U.S. generally accepted accounting principles, the statutory entity financial statements (both annual and quarterly) are prepared under statutory accounting principles, as prescribed by the various insurance departments. Due to the significant number of Parent Company statutory entities and in order to minimize the amount of paper, we would propose to provide (subject to your approval) the following information for each statutory entity in response to requirement A-5: a) Calendar Year 2006 independently audited statutory financial statements - which are the most recent audited; b) Third Quarter 2007 statutory financial statements filed with the various insurance departments - which are the most recent.	Refer to Section K of this amendment.
180 cont.				#180 cont. We would then propose to look at the year-to-date cash flows through 9/30/07 per these statements and provide explanations as requested, if appropriate. Verification of year-to-date contributions through 9/30/07 would also be provided as requested. Prior period independently audited and internally prepared statutory financial statements would be available upon request.	Refer to Section K of this amendment.
181	RFP Attach 6.3	A.5	3	Is 'Year-to-Date' defined as 12/31/07 for submission of financial statements?	"Year-to-date" refers to the any financial statements that are completed after the most recent quarterly financial statement. For example, if the most recent quarterly financial statement covers the quarter through 12-31-07, but the MCO has a statement that applies to January 2008, the MCO shall submit that statement as well.
182	RFP Attach 6.3	A.5	3	Would consolidated financial statements at the parent company level which include the combined financial results of the proposing entity, parent, subsidiaries and affiliates meet the requirements?	Yes. Refer to Section K of this amendment.
183	RFP Attach 6.3	B	4	If the Proposer is proposing to serve both the East and West Regions and the response to each item is not identical, can the term "Same as East" be used in the West Grand Region response in those instances when the response is identical?	No. If the response to any item in Section B is not identical for the East and West regions, the proposer must submit responses to both Section B:East and Section B:West.
184	RFP Attach 6.3	B	4	Are the subcontractors identified in this section only referencing those that provide services to TennCare members?	The reference in the question is not clear. In response to item B.10 of RFP Attachment 6.3, the proposer shall provide information on all subcontractors that will be used to meet the requirements of RFP Attachment 6.1.

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185	RFP Attach 6.3	B.4	5	Question asks for pending or recent (5 years) litigation filed against the Proposer, which includes parent, affiliates, and subsidiaries. Proposer is a subsidiary of a large national managed care company. The parent company has subsidiary health plans nationwide, and several subsidiaries have absolutely no Medicaid business. Several lawsuits filed against these companies are immaterial to Proposer's or its parent company's abilities regarding the TennCare program & RFP. We propose this question be limited to Proposer's/Affiliate's/Parent's/Subsidiary's Medicaid lines of business only. In the alternative, please limit the question to litigation across all lines of business, with an amount in controversy of \$1 million or more.	Refer to Section L of this amendment.
186	RFP Attach 6.3	B.4	5	Is the opinion regarding impairment of performance referencing legal impairment or does it refer to financial and/or operational issues?	The opinion should address all aspects of the proposer's performance under this agreement (RFP Attachment 6.1).
187	RFP Attach 6.3	B.4	5	Question B.4 requests that the Proposer include "...any SEC filings discussing any pending or recent litigation." Given that regulatory filing(s) can be quite voluminous, may they be submitted as attachments and not included in the page limit?	Yes. Refer to Section L of this amendment.
188	RFP Attach 6.3	B.4	13	Question B.4 states: "Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Proposer's performance in a contract under this RFP." 1. Is a formal, signed, legal opinion required? 2. May it be included as an attachment? If not, is this opinion included in page limits?	A formal, signed, legal opinion is required. It may be included as an attachment. Refer to Section L of this amendment.
189	RFP Attach 6.3	B.7	5	When defining "client base" do you only want information on service areas and member numbers OR service areas, member numbers and demographic info on these members (average age of member, average household income level, average education level, etc)?	The State would like general information on the types of clients that the proposer has (e.g., employers, unions, Medicaid agencies, federal government) and the location (e.g., in which states the proposer operates).
190	RFP Attach 6.3	B.8	5	This RFP question uses the term "project". Within this context, does "project" mean only the implementation period from the award of the contract until the start of services, or does it encompass the implementation and all contract service periods?	The proposer shall provide information about the project team, etc. for the implementation period as well during operations, to the extent that the proposer has this information.
191	RFP Attach 6.3	B.8	5 13	For "project team", do you mean the MCO's management team or the team responsible for MCO implementation? Please specify which positions, if any, must be filled when the proposal is submitted.	Project team includes all staff responsible for implementing and operating this agreement (see RFP Attachment 6.1). Refer to State's Response #190. The proposer should use its best judgment in determining which positions should be filled when the proposal is submitted.

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192	RFP Attach 6.3	B.10	5	For Proposers who must include their behavioral health subcontractor's additional information as required under this question for B.1 through B.9, B.12, B.14 through B.17, B.21, B.22, and B.24 through B.26, how should the Proposer structure this information within their proposal? Would it be acceptable to include the entire group of answers for the behavioral health subcontractor under a separate tab at the end of Section B titled Attachment B.10?	As part of its response to item B.10 (not as an attachment to B) the proposer should provide the responses to each item for subcontractor A, then subcontractor B, etc. and should clearly label each set of responses.
193	RFP Attach 6.3	B.12	15	Requirement states proposer to include Proposer's parent organization, affiliates and subs. AM Best Company only completed ratings on a select number of our subsidiaries and not the group in total. Does that make it not applicable to provide AM Best Company rating, or do we only provide for subs rated?	Provide the ratings for the subsidiaries that are rated.
194	RFP Attach 6.3	B.12	15	The rating on thestreet.com references a stock rating (buy, sell, trade) not a safety rating as stated in the requirement. Please elaborate on the rating the Bureau is requesting.	The State is seeking the Street.com safety ratings of insurers (formerly the Weiss Safety Ratings), not the investment ratings.
195	RFP Attach 6.3	B.12	15	B.12 requests ratings for the past three years from specific rating agencies. To the extent that the Company is not rated by the rating agencies, should we submit ratings for other Companies affiliated with the bidding Company? Otherwise, what information would be suggested to include?	Yes, as required by item B.12 of RFP Attachment 6.3, the proposer shall submit ratings for the proposer's affiliates.
196	RFP Attach 6.3	B.13	7	As mentioned in our question on Question A.5, the independently audited financial statements and unaudited quarterly financial statements for affiliates of the proposer are prepared under statutory accounting principles (as prescribed by the NAIC), versus under generally accepted accounting principles. Under statutory accounting principles, assets and liabilities are not reported between current and long-term. As such, (1) working capital, (2) current ratio and (3) quick ratio are not able to be calculated.	Refer to Section M of this amendment.
197	RFP Attach 6.3	B.14	7	For purposes of this question would Medicare Part D or Private Fee-For-Service business be considered a "managed care contract"?	No, for purposes of item B.14 of RFP Attachment 6.3, Medicare Part D and Medicare Private FFS are not considered "managed care contracts."
198	RFP Attach 6.3	B.16	7	This question asks the Proposer to include a copy of the applicable NCQA plan report cards. May Proposers provide these as Attachments or is it expected that we embed these in the narrative response?	The State would prefer that the proposer embed the NCQA report cards in the response. However, alternatively, the proposer may recreate the report cards in its narrative and include a print-out from the NCQA website as an attachment to Section B.
199	RFP Attach 6.3	B.18	15	Question B.18: 1) The HEDIS High Blood Pressure rates are available in 2007 for ages 18 to 45, 46 to 85, or 18 to 85. Should we use the total (ages 18 to 85) rate in our response for 2007 or ages 46 to 85 only as the rates for 18-45 are not available for 2005 and 2006? 2) There are two measures for HbA1c Control-Poor Control >9% and Good Control <7%. Should we provide both rates or just the Poor Control rate? 3) Follow-up for Children Prescribed ADHD Medication has two rates-Initiation Phase and Continuation/Maintenance Phase. Should we report both rates or just the Continuation/Maintenance Phase rate? 4) The Breast Cancer Screening rates for 2007 are available by ages 42-51, 52-69, and total 42-69. In prior years, screening was only reported for ages 52 to 69. Should we report the total rate (ages 42-69) for 2007?	In general, the proposer should provide whatever data is available, with clear labeling, even if the measure has changed and therefore is not comparable across years. As to the specific questions, for high blood pressure the proposer should include the rates available for each age group. For HbA1c control and ADHD the proposer should provide both rates. For breast cancer screening, the proposer should report each age group available for each year.
200	RFP Attach 6.3	B.19	16	The CAHPS® Adult "Getting Needed Care" question responses were modified in 2007 to allow "Usually" or "Always" answers in lieu of "Not a Problem." Should we combine the "Usually" and "Always" 2007 rate for this adult measure?	Yes, with clear labeling to that effect.
201	RFP Attach 6.3	B.20	17	B.20 refers to the entity named in B.12. B.12 does not refer to a specific entity.	The reference should be B.14. Refer to Section L of RFP Amendment #1.

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202	RFP Attach 6.3	B.20	9 17	By the "external quality review report", do you mean the technical report?	Yes, the technical report provided to the State.
203	RFP Attach 6.3	B.21	9	Are fines or corrective action plans or other settlements as a result of routine market conduct exams by state Departments of Insurance considered to be "sanctions" or "other regulatory actions"?	Yes.
204	RFP Attach 6.3	B.21	9	Please define or further explain what is meant by "letter of deficiency".	A letter of deficiency is any written notice of failure to meet a regulatory requirement.
205	RFP Attach 6.3	B.23	10	Can TennCare serve as a reference for a bidder?	No. In the past TennCare has been happy to supply references to its incumbent contractors, even on bids for its own contracts. However, those references were factual in nature asking only for information such as the existence of a contract, contract term, and scope of service. The reference requested in this RFP goes further and asks for a subjective evaluation of the contractor's performance. Therefore, in order to preserve the fairness of the RFP process neither TennCare nor other State officials or employees will supply references to incumbent bidders. References requests on other occasions will still be considered if 1) the information requested is merely factual, not subjective, and 2) if the reference request is for a bid outside of Tennessee.
206	RFP Attach 6.3	B.23	18	Does the limit on the number of references apply individually to the Proposer and each subcontractor or is the requirement for five (5) references in aggregate?	The number of references applies individually to the proposer and each subcontractor (as described in item B.23 of RFP Attachment 6.3).
207	RFP Attach 6.3	B.24	11	Proposer has several affiliates, all of which are subsidiaries of a large, national managed care parent company. In commercial lines of business, employer groups terminate/non-renew contracts for health benefit plans daily for a variety of reasons. Across all lines of business provider contracts are terminated/non-renewed as well. We propose this question be limited to termination/non-renewal of contracts (across all lines of business) of the same size/scope as TennCare. If this question is not limited accordingly, the response will be significantly voluminous and require significant and unrealistic administrative burden to answer.	Refer to Section N of this amendment.
208	RFP Attach 6.3	B.24	11	Would the State consider limiting this question to Government accounts (i.e. Medicare/Medicaid) and/or commercial accounts of similar size and scope to this contract?	Refer to State's Response #207.
209	RFP Attach 6.3	B.25	11	Proposer has several affiliates, all of which are subsidiaries of a large, national managed care parent company. We propose this question be limited to notification of breach of contracts of the same size/scope and line of business (Medicaid) as TennCare.	Refer to Section O of this amendment.
210	RFP Attach 6.3	B.25	11	The subsets of this question (1-4) seem to contemplate this is limited to Medicaid contracts. Please clarify the intent of the question.	This question does not just apply to Medicaid contracts. Refer to State's Response #209.
211	RFP Attach 6.3	B.25	19	Are we correct that proposers should only report those instances in which a Medicaid agency has actually asserted a letter with breach of contract?	No. This question is not limited to Medicaid contracts (refer to State's Response #209). In addition, this question includes all contract deficiencies (failure to meet contract requirements), not just those that would be the basis for contract termination. Refer to Section O of this amendment.
212	RFP Attach 6.3	C.1	21	Part (4) of question C.1 asks "If you will not have the same Systems for physical health and behavioral health services, how these Systems will be integrated." Please clarify whether the word "Systems" in this context means Information Systems, Delivery Systems, both, or something else entirely.	The word "Systems" in question C.1 of RFP Attachment 6.3 means Information Systems.
213	RFP Attach 6.3	C.1	21	Item (4) - does the use of the word "Systems" refer to the process around integration of the IT Systems?	Yes. Refer to State's Response #212

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214	RFP Attach 6.3	C.7	23 49	This question appears to have an incorrect reference "...described in C.8 above..." Should this reference be C.6?	Yes. Refer to Section M of RFP Amendment #1.
215	RFP Attach 6.3	C.7	49	In the text of C.7, the question refers to tracking mechanism in C.8 above (sic). Should the reference be to C.6?	Yes. Refer to State's Response #214.
216	RFP Attach 6.3	C.13	24	Need clarification of the reference in this section to Attachment 6.1, Section 2.92. Should it be Attachment 6.1, Section 2.9.2?	Yes. Refer to Section N of RFP Amendment #1.
217	RFP Attach 6.3	C.23	26	In the Technical Response and Evaluation, C. 23 asks the bidder to "Describe your philosophy regarding a medical home, including the role of the PCP in establishing a medical home for an enrollee, including referrals to specialists and when an enrollee can change his/her PCP or use another non-specialty provider." Can the state elaborate on the type of providers it was thinking about as a non-specialty provider?	Providers that provide primary care, e.g., an FQHC or a local health department.
218	RFP Attach 6.3	C.35	29	C.35 in part reads: "Regarding your UM phone line (see Attachment 6.1, Section 1.18.4)" There is no Section 1.18.4. Does the state mean Section 2.18.4?	Yes. Refer to Section Q of RFP Amendment #1.
219	RFP Attach 6.3	C.35	29	Need clarification of the reference in this section to Attachment 6.1, Section 1.18.4. Should it be Attachment 6.1, Section 2.18.4?	Yes. Refer to State's Response #218.
220	RFP Attach 6.3	C.35	29	Item C.35, part (2) reads as follows: Describe any differences between your UM phone line and your member services line with respect to items (2) through (7) in item C.36. Should the correct cross reference be item C.32?	Yes. Refer to Section Q of RFP Amendment #1.
221	RFP Attach 6.3	C.35	29	This question refers to RFP Attachment 6.1., Section 1.18.4. We are unable to locate the aforementioned Attachment 6.1, section 1.18.4 in the RFP. Will the State confirm whether the correct reference is 2.18.4?	Yes. Refer to State's Response #218.
222	RFP Attach 6.3	C.35	55	Question refers respondent to Attachment 6.1, Section 1.18.4 - should this state Section 2.18.4?	Yes. Refer to State's Response #218.
223	RFP Attach 6.3	C.35 (#2)	55	Requirement refers to items (2) through (7) in C.36. However C.36 does not have any additional requirements. Should this question C.32?	Yes. Refer to State's Response #220.
224	RFP Attach 6.3	C.35	55	Question C.35 directs the proposer to "see Attachment 6.1 Section 1.18.4" Attachment 6.1 does not contain a Section 1.18.4. Is the correct reference to Section 2.18.4?	Yes. Refer to State's Response #218.
225	RFP Attach 6.3	C.35	55	Question C.35 (2) States: "Describe any differences between your UM phone line and your member services line with respect to items (2) through (7) in item C.36;" item C.36 doesn't contain the items referenced. Is the correct reference to question C.32?	Yes. Refer to State's Response #220.
226	RFP Attach 6.3	C.38	30	When restating a question in the Proposer's response, will the restated question count toward the page limit restriction? As is the case with this question in particular (C.38 – Third Party Liability), this is a very long, multi-part question and it takes up significant amount of space within the 3-page limit that has been assigned.	The restated question counts toward the page limit restriction.
227	RFP Attach 6.3	C.40	31	Does the Bureau seek information regarding IBNR methodology for behavioral health subcontractors, or only for the bidder?	Please provide IBNR for the proposer and any behavioral health subcontractor.
228	RFP Attach 6.3	C.47	34	With respect to part b. of this question that asks for a TennCare-specific work plan regarding information systems activities from contract award to the start of operations, will the State consider allowing Proposers to provide this work plan as an Attachment, rather than embedded in the narrative portion of the proposal?	Yes. Refer to Section Q of this amendment.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
229	RFP Attach 6.3	C.47	60	C.47b asks offeror to provide a TennCare-specific work plan for implementing systems. Since a work plan of this nature could potentially be several pages long, can this be provided as an attachment and not included in the page count for this section	Yes. Refer to State's Response #228.
230	RFP Attach 6.3	C.47.b	34 60	Does TennCare have a specific format in mind for the work plan? Is MS Project acceptable?	TennCare would prefer that the work plan be in an MS Office program. MS Project is acceptable.
231	RFP Attach 6.3	C.49 C.50	35	In these sections, you are requesting diagrams, information flows, and network diagrams. Can these be attachments or do they have to be included in the 30 pages allowed?	Refer to Section R of this amendment. Attachments do not count toward the page limit.
232	RFP Attach 6.3	C.50	36	Please further define "Internal Controls" as used in subsection b.(c) of this question, and identify the state's expectations for the diagramming of such controls (e.g. examples of what types of diagrams might be expected). For example, might this be a process flow on what happens if a file is not received when expected, or does not meet specified formats?	In this contract the term "internal control" is used in a manner consistent with its use in the Sarbanes-Oxley Act of 2002. The diagrams are intended to provide insight into how the proposer has set up internal controls to ensure the integrity and validity of the data that it manages in its information systems.
233	RFP Attach 6.3	C.50	62	C.50b asks offerors to provide diagrams that illustrate a) point-to-point interfaces, b) information flow, c) internal controls, and d) the networking arrangement. These diagrams will potentially require 5-10 pages for display. Can these be presented as attachments and not count against the page limitation for this section? In addition, some of these diagrams are extremely large and may require printing on paper larger than 8 1/2 x 11 in order for them to be readable. Can these diagrams be submitted in a format other than the 8 1/2 x 11 format of the narrative?	Regarding including this information as an attachment, refer to State's Response #231. It is acceptable to include this information on larger paper if it is folded to fit neatly in the binder and easy to unfold.
234	RFP Attach 6.3	C.57	65	Is the detailed profile of key information systems excluded from the page limit for this section?	This profile should be an attachment and as such will not count against the page limit.
235	RFP Attach 6.3	C.58	65	Is the profile of our Information Systems Organization excluded from the page limit for this section?	This profile should be an attachment and as such will not count against the page limit.
236	RFP Attach 6.3	C.58	65	This requirement says to follow the instructions in RFP attachment 6.9 for completing this profile. The instructions provide direction for completing the first page, but do not provide assistance with the second page. Can the Bureau provide some additional instruction about the information being requested in each of the Notes columns on the second page of the profile? In particular, what does the Bureau mean by "allocation basis" in the first column on the second page?	Refer to Section T of the amendment.
237	RFP Attach 6.3	C.61	67	Are the "non-traditional A&D providers" the same as community based alternatives or something different? Please provide respondent with specific types of non-traditional A&D providers that the Bureau would like to participate.	"Non-traditional A&D providers" are those that are not currently participating in the TennCare program.
238	RFP Attach 6.3	C.63	42	Regarding C.63, did the State intend to reference C.62 instead of C.22?	Yes. Refer to Section T of RFP Amendment #1.
239	RFP Attach 6.3	C.63	68	This question refers respondent to item C.22. Should this reference C.62?	Yes. Refer to State's Response #238.
240	RFP Attach 6.3	C.63	68	Question C.63 states: "How do you plan to address the observations and challenges unique to this Grand Region identified in C.22 above. . ." However, question C.62 requires a description of observations and challenges identified in the completion of the Contact Memorandums while C.22 describes the PCP assignment process. Which question (C.22 or C.62) is the correct reference?	C.62. Refer to State's Response #238.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
241	RFP Attach 6.3	C.63	42 68	Question C.63 for both the East and West bids appears to be referring to an incorrect reference. C.63 refers back to item C.22 and it appears as if it should be C.62. Please confirm.	Yes. Refer to State's Response #238.
242	RFP Attach 6.3	C.64	42	Regarding C.64, did the State intend to reference C.63 instead of C.23?	Yes. Refer to Section U of RFP Amendment #1.
243	RFP Attach 6.3	C.64	68	This question refers respondent to item C.23. Should this reference C.63?	Yes. Refer to State's Response #242.
244	RFP Attach 6.3	C.64	68	Question C.64 states: "For provider types not addressed in response to C.23 describe your plan to build and maintain a provider network." However, question C.23 pertains to our philosophical approach to a Medical Home. Is the correct reference question C.63?	Yes. Refer to State's Response #242.
245	RFP Attach 6.3	C.64	42 68	Question C.64 for both the East and West bids appears to be referring to an incorrect reference. C.64 refers back to item C.23 and it appears as if it should be C.63. Please confirm.	Yes. Refer to State's Response #242.
246	RFP Attach 6.3	C.63 C.64	42 68	In Sections C.63 and C.64, the proposer is referred back to Sections C.22 and C.23. These sections address PCP assignment and a member's medical home. Is this the appropriate reference or did you mean Sections C.62 and C.63?	Yes. Refer to State's Response #238 and #242.
247	RFP Attach 6.3	C.65	68	Please confirm that TennCare is only looking for ER utilization data for "November 2006 and May 2007".	Correct. The State is only looking for data for those two time periods.
248	RFP Attach 6.3	D	72	Should copies of Contact Memorandums be submitted as an attachment? It is unclear in Section D; however, RFP Attachment 6.11, Notice of Intent to Issue RFPs, indicates they are to be submitted with the proposal.	The contact memorandums should be included as part of Section D (after the applicable Guide to Section D), not as an attachment. Refer to Section 3.2.3 of the RFP.
249	RFP Attach 6.3	D	72 74	The instructions to Section D state: "The RFP Coordinator will independently evaluate and score the number of Contact Memorandums. The information in the Contact Memorandums will be subject to verification by the State." Will the State make any allowance in scoring when providers refuse to sign a Contact Memorandum even after the Proposer has made several documented face-to-face visits?	In accordance with RFP Attachment 6.11, for hospitals the proposer may select another hospital within the Grand Region. For the other provider types where the State identified providers by name in RFP Attachment 6.11 (e.g., CMHAs, LHDs, and RMHIs/private hospitals), the State will make an allowance in scoring if the proposer provides evidence of face-to-face contact with the provider, including contact information so that the State can confirm the information provided by the proposer.
250	RFP Attach 6.3	E	76 77	With respect to the arrangements for orals, may we know the following: 1) Will these be panels discussions? 2) How many people will be in the room? 3) How will the room be set up? 4) May we have people available for back up even if they are outside the room during the oral evaluation? 5) May we have people there to help the Team prepare during the 45 minute period when the questions are made known before the oral evaluations begin? 6) Will there be a time limits for each question and answer? 7) During the oral evaluation, will the Proposer be able to step out and make a phone call (as CMS allows during their Medicare bids)?	The State will ask the proposer a question, give the proposer (including any team member) an opportunity to respond, then will ask the next question, etc. In addition to the proposer's team, there will be 10-12 other people, including the State's evaluation teams and the RFP coordinator. The set-up of the room has not been determined, but it is expected that the proposer's team will sit together in a square or horseshoe formation with the State's evaluation team members making up the other part of the square or horseshoe. No, the proposer may not have back up people. Yes, the proposer may have people to help the team prepare during the 45 minutes prior to the oral evaluation. Yes, there will be time limits for each response. No, the proposer will not be able to step out and make a phone call.
251	RFP Attach 6.3	NA	NA	There appear to be discrepancies regarding the overall number of points available and regarding those available for the contact memorandum (in the introduction to the RFP and in Section 6.3)	The State was unable to find the discrepancy. There are 50 points available in each region for the contact memorandums.
252	RFP Attach 6.7		1	We may be using two actuarial firms in developing our response to the cost proposal - one for the medical expense portion excluding mental health and the other for mental health services. As a consequence, we will have two actuaries signing the Cost Scoring and Cost Proposal forms, one for the medical component and the other for the mental health component. Is this acceptable to the State?	Yes.
253	RFP Attach 6.8	NA	1	If the Contractor currently has or will have multiple systems in place for specific functions in the IS profile, can the State verify that all pertinent such applications should be highlighted?	Yes.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
254	RFP Attach 6.8		1	Section asks for the name of the database. Is that the type of database (i.e. SQL 2005 or Oracle) or is it the actual database name (i.e. Northwinds)?	Type of database (DBMS vendor/product name and release level). For example, Oracle 9i.
255	RFP Attach 6.9	NA	1	For the IS organizational Profile, can the State specify the job categories to place server technicians, storage technicians, and management personnel into, or is it leaving it up to the Contractor to place personnel in the most appropriate categories?	The Bureau defers to each proposer for categorizing and accounting for personnel in a manner consistent with its job classification structures.
256	RFP Attach 6.10	C.72	1	Question C.72 references Attachment 6.10. This attachment includes three columns - the first column indicating the benefit category and the third referencing the percent change in utilization included in the cost proposal. There is no heading on the second column - should there be? Is there an intent that there will be information included in the second column?	The second column is just cosmetic. There is no heading for the second column, and the State does not intend that the proposer will provide information in the second column. Refer to Section U of this amendment.
257	RFP Attach 6.10		1	Can the managed care utilization impact assumptions in Attachment 6.10 vary by age-gender-eligibility cohort? May multiple Attachments 6.10 be submitted for different age-gender-eligibility cohorts?	No. However, the proposer may include that information in the narrative explanation in response to item C.72 of RFP Attachment 6.3.
258	RFP Attach 6.10		1	Can the actuarial signature for Attachment 6.10 be eliminated? The managed care impact is more a medical management decision versus actuarial.	No.
259	RFP Attach 6.10, 6.12, & 6.13	NA	1	Will the Bureau accept electronic signatures on these exhibits?	Yes.
260	RFP Attach 6.13	NA	1	We may be using two actuarial firms to develop our response to the cost proposal - one for the medical expense portion excluding mental health and the other for mental health services. As a consequence, we may have two actuaries signing the Cost Scoring and Cost Proposal forms, one for the medical component and the other for the mental health component. Is this acceptable to the State?	Refer to State's Response #252.
261	RFP Attach 6.14 & 6.15	NA	1	Please provide the fees schedules in use in FY06 and FY07 for IP, OP and Physician. If these are not available, please provide the Medicare fee schedule equivalent for the time period (for example - fees were equivalent to 68% of Medicare fee schedule)	There is no single fee schedule available and Medicare equivalence varies significantly by category. Unit costs are provided in the data books (RFP Attachment 6.14 and 6.15) and can be calculated by the proposer.
262	RFP Attach 6.15	NA	1	Clinics (billed on a hospital bill) - are they classified as outpatient or professional in the data used by AON?	If they were billed on the UB-92 form they would be under the outpatient hospital category.
263	RFP Attach 6.14 & 6.15	NA	6	Can the State identify any notable issues that have occurred in the past where duplicate members have been identified in the eligibility process? What was the magnitude and outcome in resolving the issue(s)?	While there have not been notable issues related to duplicate members, TennCare does receive eligibility information from multiple sources which can cause duplicate members to be created. The State has a linking process within its MMIS to resolve these duplicate members when they are identified. This information is then transmitted to the MCOs via 834 transaction.
264	RFP Attach 6.15	B	9	Could additional detail (Purpose, Scope, Grantee, Amount of Grant) be provided related to the Grants referenced in this Attachment?	Please see the Grant section of the data book for a listing of the grants included.
265	RFP Attach 6.14 & 6.15	Section IV	15	Is there experience to validate that the removal of the 5 prescription limit does not have an impact on prior utilization levels?	Yes.
266	RFP Attach 6.15		15	How many ungroupable (DRG 470) or DRG 469 claims were included in the data when grouped as DRG ver 24?	The data was grouped with Version 24.0 only. For counts refer to Section V and Section W of this amendment (revised Exhibit 19). No admissions were excluded.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
267	RFP Attach 6.15	C	16	1) Radiology and Laboratory units are counted as services when on an outpatient claim. How are they counted within the hierarchy - for example, if a claim is already classified as an ER claim, would any radiology/lab items on the claim be counted or since it was already classified as an ER claim, the radiology/lab items on the claim are not counted? 2) If a claim is classified as a lab/rad claim based on the hierarchy, would we count all lines on the claim or just the lab/rad lines on the claim to determine the lab/rad services?	1. If a claim is classified as an ER claim all the claim lines would roll-up under the ER claim. This claim would then be counted on a claim basis vs. services. 2. If not classified under ER or Surgery, the radiology and lab claims are on a service level.
268	RFP Attach 6.15	C	20	Can the Data Book be updated to include admissions in addition to days - Exhibits 1 through 17?	Admission information can be found in Exhibit 19 Inpatient DRGs (refer to Sections V and W of this amendment for revised Exhibit 19). The data book cannot be updated.
269	RFP Attach 6.15	D	21	TennCare Select High Enrollees are removed from the analysis because they are not mandated to enroll in managed care. Can they choose managed care? To the extent that they have the ability to choose managed care, their costs are simply not considered in developing the rate ranges?	TennCare Select High enrollees will not be assigned to the contractors.
270	RFP Attach 6.14	E	23	Since transportation is partially capitated, is it possible that the encounter data is understated?	The transportation capitation amount is included in the data books (RFP Attachment 6.14 and 6.15)
271	RFP Attach 6.15	E	23	For inpatient hospital services, were hospitals being reimbursed on a per diem, per admission or percent of charges basis during SFY 2005? If multiple reimbursement methodologies were applied, please provide estimated volume under each methodology.	Information is not available.
272	RFP Attach 6.15	E	23	For outpatient emergency room and surgical services, how were hospitals being reimbursed during SFY 2007 – percent of charges or other methodology to be described? What was the most common reimbursement methodology?	Information is not available.
273	RFP Attach 6.15	N/A	24	Grants did not receive any increase or trend assumptions with the RFP indicating that they are capped at the total budgeted amount with no true trend component. Can we have further information on grants? Are they just a pass through from the State to the MCO to the provider?	Please see the Grant section of the data book for a listing of the grants included. The MCOs may use grants in their discretion as they deem appropriate.
274	RFP Attach 6.14 & 6.15	Section VI	27	Can Aon provide the grouping logic used to combine diagnostic codes, procedure codes, revenue codes, and claim type indicators into the various detailed service categories?	Refer to the service category write-up in the data books (RFP Attachment 6.14 and 6.15).
275	RFP Attach 6.14	Exhs 1-4	28	It appears that there is a substantially different counting methodology for Home Health Care in the East and West data books when compared to the Middle Grand Region data book. The MGR HHC util/1,000 for the population for FY2005 = 56; the East data book shows 1,815 for FY2007. Can the State provide more detail on the counting methodology and the make-up of the claim costs?	Home health was summarized on a claims count basis. Home health has shown significant differences in how it is being reported between the regions. Also note the per service cost varies as well. The proposer should concentrate their efforts on the overall PMPM for this category.
276	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Are the stated transportation units (trips) describing round trips or one-way trips?	We would expect them to be reported as round trips but the units would be consistent with how they are paid.
277	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Can the stated transportation units be broken down to show units by county or by HRA service area?	The information is not readily available.
278	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Can member months for the stated time periods be provided (preferably by county)?	Refer to State's Response #88.
279	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Can the stated transportation units be broken to show units by each covered level of service such as ambulatory, wheelchair, invalid vehicle, non-emergency ambulance?	Some additional procedure data can be found in the supplemental exhibits in the data books (RFP Attachment 6.14 and 6.15). See, e.g., Exhibit 24 professional.
280	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Does the transportation data shown include emergency ambulance?	Yes.
281	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Is transportation to mental health facilities a covered service? If so, are these trips included in data presented in the data book?	Yes is it covered and it is included in the data books (RFP Attachment 6.14 and 6.15) under mental health.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
282	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Assuming mental health trips are included in the service category NPMH, this utilization appears very low compared to what we experience in other markets. Is this a limited benefit?	It would also be included under the priority rate. It is not a limited benefit.
283	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Are there any transportation expenses not shown within the data book that may have been paid by another agency?	Not that the State is aware of.
284	RFP Attach 6.14 & 6.15	Exh 1 and others	28	Similar state markets which include Dialysis and Mental Health have much higher utilization rates than what is depicted in the data book. Why is the utilization in these regions so low?	A detailed comparison has not been developed for these groups. The data is an accurate representation of the experience in these regions.
285	RFP Attach 6.14 & 6.15	Exh 10 and others	28	Do the transportation PMPM rates presented include any costs associated with transportation-related administrative fees such as call taking, call center operations or reporting?	Yes.
286	RFP Attach 6.14 & 6.15	Exhs 1 - 7	28	During the experience period, many claims have been denied due to providers lacking a TennCare Medicaid ID number. These claims will ultimately be paid. What is the adjustment in the data book for these unpaid claims?	This has not been a significant issue in the State. The IBNR factors would compensate for any lag time in reimbursements.
287	RFP Attach 6.14 & 6.15	Section VI	31	Can Aon provide the list of the required member cost sharing provisions?	This information can be found on the TennCare website at http://tennessee.gov/tenncare/mem-copayments.html .
288	RFP Attach 6.14 & 6.15	Exhs 1 - 4	33	The data book shows significant newborn costs under the adult female categories. How are newborn costs handled? Will newborn cap payments be made retroactively to the newborn's date of birth? Should MCOs consider delivery and newborn costs part of the mother's costs or should the newborn cap payment cover ALL newborn costs?	The newborn cap should cover the expected costs of the newborn and the cap would be made retroactively to date of birth. It is possible that there are claims submitted for newborns that are tied to the mother's ID. These claims could end up in the adult female cell creating a small load on that cell.
289	RFP Attach 6.14 & 6.15	Section VII	35	Can Aon provide the grouping logic used to combine diagnostic codes, procedure codes, revenue codes, and claim type indicators into the various detailed service categories?	Refer to State's Response #274.
290	RFP Attach 6.14 & 6.15	Section VIII	39	Can Aon provide the grouping logic used to combine diagnostic codes, procedure codes, revenue codes, and claim type indicators into the various detailed service categories?	Refer to State's Response #274.
291	RFP Attach 6.14	Exh 7	48	The Home Health/Private Duty Nursing trend assumption in the RFP is 15% annual trend. The base data provided in the RFP for East and West Grand Regions indicate an annual Home Health trend of 44.5% and 34.9%, respectively. In addition, the FY 2009 Budget Recommendation presentation indicated a 53% annual trend in Home Health/Private Duty Nursing services. What specific assumptions (i.e., benefit changes, regulatory mandates, court rulings, etc.) were used to reduce the trend assumption to 15%? Can you help us understand the variance between the 15% versus 53% trend factors (i.e., benefit changes, regulatory mandates, court rulings, etc.)?	Historical experience alone is not an indication of future trends. A 50% trend rate would not be a reasonable assumption given the projection period. There are negligible managed care savings assumed for home health.
292	RFP Attach 6.14	Exh 7	48	If these changes (i.e. benefit changes, mandatory, court rulings) are not implemented, will the rates be adjusted or will the annual trend rate assumption be modified?	Any change in benefits not incorporated into the rate development would result in the rates being adjusted appropriately.
293	RFP Attach 6.14 & 6.15	Exh 7 Exh 22	48	In 6.15, Total Home Health Cost in Exhibit 22 (page 158) for FY 2007 high dollar claimants exceeding >\$50K is \$69.2M, while the Total Home Health Cost for ALL claimants in Exhibit 7 (page 48) is only \$27.8M. Appears to be an inconsistency in the reporting. (Similar to Exhibit 6.14) Is this something that can be investigated?	A formula in the supplemental report Exhibit 22 has been corrected. Refer to Sections W and X of RFP Amendment #1.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
294	RFP Attach 6.15	Exh 7 Exh 22	48 158	In Attachment 6.15, West Tennessee Data Book, FY 2006 and 2007, Exhibit 7 (page 48), paid expenditures for Home Health Care are listed at \$27,817,110. Exhibit 22 (page 158) of Attachment 6.15 has total Home Health expenditures of \$69,228,835. Can you verify which of these two exhibits accurately reflects Home Health expenditures, or if a classification discrepancy exists, can you provide the criteria used to pull each category?	Refer to State's Response #293.
295	RFP Attach 6.15	Exh 10	52	Based on our analysis of available information, the member months reported in the data book for the Under 1 Medicaid category are roughly equivalent to the total Under 1 Medicaid member months for one of the current vendors. Please review and confirm that the member months in the data book are accurate.	The members months are calculated from the eligibility files received from the Bureau.
296	RFP Attach 6.14 & 6.15	Exh 12	63	In order to assist with compiling complete and accurate projections, would the state share the experience of the newest at-risk MCOs in the Middle Grand Region for the PDN component of home health care costs?	This information is not available at this time.
297	RFP Attach 6.15	Exh 19	104	Can the paid amount by DRG be added to the number of admissions and days data?	Consistent with the Middle RFP the Bureau does not believe it is appropriate to release this information.
298	RFP Attach 6.14 & 6.15	Exh 19	109	In Exhibit 19 of the East & West TN data books, discrepancies between the DRG numbers and associate descriptions exist. For example, DRG numbers 54 through 56, in the data book, have descriptions relating to "Other disorders of the eye, age..." Those descriptions should map to DRG numbers 46 through 48. The CMS descriptions of DRG numbers 54 through 56 should be as follows: DRG number 54 = "Sinus & mastoid procedures age 0-17"; DRG number 55 = "Miscellaneous ear, nose, mouth & throat procedures"; and, DRG 56 = "Rhinoplasty." Can you confirm the days and admissions associated with each DRG number indicated in the table are accurately matched?	The text has been corrected. Refer to Sections V and W of this amendment. The information within the DRG number is correct, only the text was updated.
299	RFP Attach 6.15	Exh 20	116	What is the SFY 2007 ACG risk factor for the Western Region?	The value would not provide significant information to the proposer. The calculated factor is a relative number and has only been used to track changes over time. We would direct you to Exhibit 20 of the data book (RFP Attachment 6.14 and RFP Attachment 6.15) for further information. The factor will be calculated for the baseline contract period and used to adjust the risk between the MCOs only.
300	RFP Attach 6.14	Exh 22	127	The total amount of home health care paid claims was \$56.5 million (from Exh 7, p. 48) in FY07. The High Dollar Claim Report shows \$58 million of HHC claims incurring within large claims. Is this exhibit mislabeled (inpatient and HHC dollars are reversed)? Please explain this discrepancy.	Refer to State's Response #293.
301	RFP Attach 6.15	Exh 23	159	Can the paid dollar amounts be provided by Provider ID in addition to the claim count?	That information is proprietary and cannot be released.
302	RFP Attachs	All	NA	Each section of the RFP follows its own formatting standards. Are our responses required to be in that format?	The question is not clear. In general, except for the information provided in the RFP to be included in the proposer (e.g., the guide for Section A in RFP Attachment 6.3), the proposer's proposal should be in a consistent format, including font, font size, margins, etc. Note that each Section should be separately numbered; attachments should be clearly labeled, included (in order) at the end of the applicable section, and may be numbered separately.
303	RFP Attachs	All	NA	Do you have a preferred font?	The State has a slight preference for Arial or Times New Roman, but this is up to the proposer.
304	TennCare Medicaid	Chapter 1200-13-13-08.g.	52	Does Tennessee have a website for verification of provider Medicaid number/participation?	No.

#	Document Reference	Section Number	Page # in Ref. Doc.	Question	Response
305	TennCare Medicaid	NA	NA	We have heard the Governor speak about transforming the long term care (LTC) system. Is it possible that this transformation could involve integrating LTC with physical and behavioral health care as a managed care organization (MCO) responsibility?	All system delivery models are currently under consideration - so yes, that is a possibility. The LTC system transformation is currently still under consideration by TennCare for future implementation. Because the change/direction has not yet been finalized, no information regarding full integration of LTC with physical and behavioral health care should be included by a proposer in its proposal. The proposer should respond to questions in the RFP (Attachment 6.3) based on the requirements in the pro forma contract (RFP Attachment 6.1).

C. Delete RFP Section 3.2.4 in its entirety and insert the following in its place:

- 3.2.4 Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be typed on standard 8 1/2" x 11" paper, single spaced, and single sided. Except for tables, text boxes, and graphics, text shall be no smaller than 11-point font. The text in tables, text boxes, and graphics shall be no smaller than 8-point font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the Proposer's name. Attachments must be clearly labeled.

D. Delete RFP Section 4.3.6 in its entirety and insert the following in its place:

- 4.3.6 A Proposer shall not submit more than one Technical Proposal in response to this RFP nor submit more than one Cost Proposal per Grand Region. Submitting more than one Technical Proposal or submitting more than one Cost Proposal per Grand Region shall result in the disqualification of the Proposer. Proposer shall include the Proposer's parent organization, affiliates, and subsidiaries.

E. Delete RFP Section 5.2.3.5 in its entirety and insert the following in its place:

- 5.2.3.5 During the Oral Evaluation the evaluators will ask questions about the Proposer's Technical Proposal in the areas identified in RFP Attachment 6.3, Section E. Discussion or disclosure of any Cost Proposal amounts or any cost information during the Oral Evaluation shall make the proposal non-responsive and the State shall reject it.

F. Delete Section 2.6.1.2.5 of RFP Attachment 6.1 in its entirety and insert the following in its place:

- 2.6.1.2.5 As required in Section 2.9.4.2.2, the CONTRACTOR shall provide MCO case management to members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide MCO case management to enrollees with co-morbid physical health and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's MCO case managers collaborate and communicate in an effective and ongoing manner.

G. Delete Section 2.13.2 of RFP Attachment 6.1 in its entirety and insert the following in its place:

2.13.2 All Covered Services

- 2.13.2.1 Except for covered services for which there is no Medicare reimbursement methodology as provided in Sections 2.13.2.2 and 2.13.2.3 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.
- 2.13.2.2 For covered services for which there is no Medicare reimbursement methodology, tThe CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered services for which there is no Medicare reimbursement methodology.
- 2.13.2.3 As part of a stop-loss arrangement with a provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

H. Delete Section 2.17.5.4 of RFP Attachment 6.1 in its entirety and insert the following in its place:

- 2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the

newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 4.20 of this Agreement.

I. Delete Section 3.13.1.2 of RFP Attachment 6.1 in its entirety and insert the following in its place:

3.13.1.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment pursuant to Section 3.4 above, the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances. This adjustment shall be based on consultation with the State's independent actuary.

J. Add the following as Section 4.4.4 of RFP Attachment 6.1 and renumber any subsequent sections and cross-references as necessary:

4.4.4 Termination Due to Change in Ownership

4.4.4.1 In the event that an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 4.4.1.

4.4.4.2 In the event that the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) of an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 4.4.1.

4.4.4.3 If an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, or the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in an entity that contracts with TENNCARE to provide covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, the CONTRACTOR shall notify TENNCARE and shall provide TENNCARE with regular updates regarding the proposed acquisition.

K. Delete item A.5 in RFP Attachment 6.3, Section A in its entirety and insert the following in its place:

A.5 Provide the following for the Proposer's parent organization as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:

- (1) The most recent independently audited consolidated financial statements and associated enrollment figures. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: (1) prepared with all monetary amounts detailed in U.S. currency; (2) prepared under U.S. generally accepted accounting principles (GAAP); and (3) audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.
- (2) The four (4) most recent internally prepared unaudited consolidated quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.

- (3) Verification of any contributions made to the Proposer's parent organization to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable.

If the Proposer does not have a parent company, the Proposer shall provide the information listed in (1) through (3) above for the Proposer company. If the financial statements are prepared under statutory accounting principles and not GAAP, please provide an explanation.

L. Delete item B.4 in RFP Attachment 6.3, Subsection B:East and item B.4 in RFP Attachment 6.3, Subsection B:West in their entirety and insert the following in their place:

- B.4** Provide a statement of whether there is any pending or recent (within the past five years) litigation against the Proposer. This statement shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against the Proposer, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include as an attachment an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Proposer's performance in a contract under this RFP. Also include as an attachment any SEC filings discussing any pending or recent litigation. The Proposer shall provide the required information for any recent or pending litigation against the Proposer or the Proposer's parent organization, affiliate or subsidiary where the amount in controversy is \$1 million or more as well as any recent or pending litigation against the Proposer or the Proposer's parent organization, affiliate or subsidiary that is related to a public sector contract (including, but not limited to, Medicaid, Medicare, SCHIP, and public employees).

M. Delete item B.13 in RFP Attachment 6.3, Subsection B:East and item B.13 in RFP Attachment 6.3, Subsection B:West in their entirety and insert the following in their place:

- B.13** Please provide the following information (in table format) based on each of the financial statements provided in response to item A.5:

- (1) Working capital;
- (2) Current ratio;
- (3) Quick ratio;
- (4) Net worth; and
- (5) Debt-to-worth ratio.

If the information is for the Proposer's organization (not the Proposer's parent organization since there is no parent organization), please provide an explanation. If the financial statements provided in response to item A.5 are prepared under statutory accounting principles, the Proposer shall provide the above information based on the statutory financial statements and shall provide an explanation to that effect.

N. Delete item B.24 in RFP Attachment 6.3, Subsection B:East and item B.24 in RFP Attachment 6.3, Subsection B:West in their entirety and insert the following in their place:

- B.24** Identify whether the Proposer (to include the Proposer's parent organization, affiliates and subsidiaries) has had a contract terminated or not renewed within the past five (5) years. If so, please describe the reason(s) for the termination/non-renewal, the parties involved, and provide the address and telephone number of the client. If the contract was terminated/non-renewed based on the Proposer's performance, please describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The Proposer shall provide the required information for all public sector contracts (including, but not limited to, Medicaid, Medicare, SCHIP, and public employees) as well as any non-public sector contracts that cover more than 200,000 lives.

- O. Delete item B.25 in RFP Attachment 6.3, Subsection B:East and item B.25 in RFP Attachment 6.3, Subsection B:West in their entirety and insert the following in their place:**

B.25 For any of the Proposer's (to include the Proposer's parent organization, affiliates and subsidiaries) contracts to provide physical or behavioral health services within the past five years, has the other contracting party notified the Proposer that it has found the Proposer to be in breach of the contract (failed to meet a contract requirement)? If yes:

- (1) Please provide a description of the events concerning the breach, specifically addressing the issue of whether the breach was due to factors beyond the Proposer's control.
- (2) Was a corrective action plan (CAP) or its equivalent imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed.
- (3) Was a sanction imposed? If so, please describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage)
- (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation?

The Proposer shall provide the required information for all public sector contracts (including, but not limited to, Medicaid, Medicare, SCHIP, and public employees) as well as any non-public sector contracts that cover more than 200,000 lives.

- P. Delete C.30 in RFP Attachment 6.3, Subsection C.I:East and item C.30 in RFP Attachment 6.3, Subsection C.I:West in their entirety and insert the following in their place:**

C.30 Describe the proposed content for your member newsletters (see RFP Attachment 6.1, Section 2.17.5) and attach a sample draft general newsletter and teen/adolescent newsletter for TennCare enrollees. Please include the newsletters in MS Word in the electronic copies of your Technical Proposal (see Section 3.1.2.3).

- Q. Delete part b. of item C.47 in RFP Attachment 6.3, Subsection C.II:East and part b. of item C.47 in RFP Attachment 6.3, Subsection C.II:West in their entirety and insert the following in their place:**

- b. Please include as an attachment a TennCare-specific work plan that captures (1) key activities and timeframes and (2) projected resource requirements from your organization for implementing information systems in support of this contract. The work plan should cover activities from contract award to the start date of operations.

- R. Delete part b. of item C.50 in RFP Attachment 6.3, Subsection C.II:East and part b. of item C.50 in RFP Attachment 6.3, Subsection C.II:West in their entirety and insert the following in their place:**

- b. As part of your response, provide as an attachment diagrams that illustrate (a) point-to-point interfaces, (b) information flows, (c) internal controls and (d) the networking arrangement (AKA "network diagram") associated with the information systems profiled. These diagrams should provide insight into how your Systems will be organized and interact with TennCare systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with TennCare.

- S. Delete C.61 in RFP Attachment 6.3, Subsection C.III:East and item C.61 in RFP Attachment 6.3, Subsection C.III:West in their entirety and insert the following in their place:**

C.61 Tennessee would like to see an increase in community based alternatives to residential treatment for alcohol and drug services. Describe your plan for developing community based alternatives to residential treatment and how you will build your network to increase A&D community capacity. In addition, describe how you will increase participation by non-traditional A&D providers in the TennCare program.

T. At the end of RFP Attachment 6.9, insert the following:

Instructions for 2nd page of table:

1st column (Notes/Comments): If an allocation basis was used to determine the number of staff that will support the Proposer's systems for the TennCare Agreement, please enter this information here. For instance, a TennCare MCO may receive IT support services from the MCO's parent organization, and staff within that parent organization may allocate 10, 20, 30% etc. of their time to supporting the TennCare MCO.

2nd column (Avg. # Hours per Year, Professional Development): Please enter the avg. no. of hours in a calendar year that staff within each IS org. job class spend on professional development activities (formal training, refresher courses, peer group seminars/conferences, etc.).

3rd column (Notes/Comments): Please elaborate/cite examples of the courses (and the subject of said courses) being taken by staff within each IS organization job class. The hours associated with these courses should be included in the figures entered in the 2nd column.

4th column (Turnover Rate): Please enter the avg. no. of staff (expressed as FTEs) by IS job class who separate from the "organization" (organization herein defined as: the TennCare MCO, its parent's IT organization if possible, and any IT outsourcer who would provide services to the TennCare MCO) each year as a percentage of all FTEs in that job class across this "organization".

5th column (Notes/Comments): Use this field to elaborate on special circumstances or aspects of the MCO's IT support organization that may further explain the turnover levels identified on the first page of the IS Organization Profile.

U. Delete RFP Attachment 6.10 in its entirety and insert the attached, revised RFP Attachment 6.10 in its place.

V. Delete Exhibit 19 in RFP Attachment 6.14 in its entirety and insert the attached, revised Exhibit 19 in its place.

W. Delete Exhibit 19 in RFP Attachment 6.15 in its entirety and insert the attached, revised Exhibit 19 in its place.

ATTACHMENT 6.10

SUMMARY OF KEY UTILIZATION ASSUMPTIONS

	Managed Care Utilization Impact (State as a Percentage)
Home Health Care	
IP - Maternity	
IP - Newborn	
IP - Medical	
IP - Surgery	
IP - Other	
OP - Emergency Room	
OP - Laboratory	
OP - Radiology	
OP - Surgery	
OP - Other	
Prof - Evaluation & Management	
Prof - Maternity	
Prof - Surgery	
Prof - DME/Supplies	
Prof - Lab	
Prof - Radiology	
Prof - Transportation	
Prof - Other	
NPMH - Inpatient	
NPMH - Inpatient RMHI	
NPMH - Outpatient	
NPMH - Case Rates	
NPMH - Grants	
NPMH - In-Home Services	
NPMH - Supported Housing	
NPMH - 23 Hour	
NPMH - Intensive Outpatient	
NPMH - Partial Hospitalization	
NPMH - Transportation	

Actuary Signature

Actuary Name (Printed)

Actuary's Firm, if any

Date

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
1	CRANIOTOMY AGE >17 W CC	Surgical	20	142
2	CRANIOTOMY AGE >17 W/O CC	Surgical	14	62
3	CRANIOTOMY AGE 0-17	Surgical	27	200
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	Surgical	17	291
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	Surgical	2	6
9	SPINAL DISORDERS & INJURIES	Medical	25	414
10	NERVOUS SYSTEM NEOPLASMS W CC	Medical	68	408
11	NERVOUS SYSTEM NEOPLASMS W/O CC	Medical	54	936
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	Medical	838	19,077
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	Medical	35	468
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	Medical	321	2,622
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	Medical	86	912
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	Medical	30	246
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	Medical	20	351
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	Medical	116	551
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	Medical	31	81
21	VIRAL MENINGITIS	Medical	60	192
22	HYPERTENSIVE ENCEPHALOPATHY	Medical	5	59
23	NONTRAUMATIC STUPOR & COMA	Medical	23	98
26	SEIZURE & HEADACHE AGE 0-17	Medical	175	486
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	Medical	55	408
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	Medical	30	186
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	Medical	24	365
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	Medical	52	172
31	CONCUSSION AGE >17 W CC	Medical	10	28
32	CONCUSSION AGE >17 W/O CC	Medical	6	11
33	CONCUSSION AGE 0-17	Medical	9	17
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	Medical	93	589
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	Medical	103	1,338
37	ORBITAL PROCEDURES	Surgical	3	11
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	Surgical	2	3
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	Surgical	6	13
43	HYPHEMA	Medical	6	29
44	ACUTE MAJOR EYE INFECTIONS	Medical	19	64
45	NEUROLOGICAL EYE DISORDERS	Medical	8	25
46	OTHER DISORDERS OF THE EYE AGE >17 W CC	Medical	7	25

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	Medical	6	22
48	OTHER DISORDERS OF THE EYE AGE 0-17	Medical	17	40
49	MAJOR HEAD & NECK PROCEDURES	Surgical	2	3
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	Surgical	2	9
52	CLEFT LIP & PALATE REPAIR	Surgical	6	9
54	SINUS & MASTOID PROCEDURES AGE 0-17	Surgical	1	7
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	Surgical	2	8
56	RHINOPLASTY	Surgical	2	11
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	Surgical	6	9
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	Surgical	15	52
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	Surgical	1	2
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	Surgical	4	8
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	Surgical	7	14
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	Surgical	13	65
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	Medical	73	935
65	DYSEQUILIBRIUM	Medical	25	121
66	EPISTAXIS	Medical	7	13
67	EPIGLOTTITIS	Medical	2	9
68	OTITIS MEDIA & URI AGE >17 W CC	Medical	50	185
69	OTITIS MEDIA & URI AGE >17 W/O CC	Medical	28	70
70	OTITIS MEDIA & URI AGE 0-17	Medical	212	552
71	LARYNGOTRACHEITIS	Medical	32	54
72	NASAL TRAUMA & DEFORMITY	Medical	3	12
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	Medical	20	61
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	Medical	49	181
75	MAJOR CHEST PROCEDURES	Surgical	47	535
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	Surgical	39	382
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	Surgical	2	8
78	PULMONARY EMBOLISM	Medical	117	709
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	Medical	248	1,929
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	Medical	12	114
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	Medical	38	257
82	RESPIRATORY NEOPLASMS	Medical	236	2,543
83	MAJOR CHEST TRAUMA W CC	Medical	14	79
84	MAJOR CHEST TRAUMA W/O CC	Medical	1	3
85	PLEURAL EFFUSION W CC	Medical	29	191

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
86	PLEURAL EFFUSION W/O CC	Medical	1	5
87	PULMONARY EDEMA & RESPIRATORY FAILURE	Medical	569	4,485
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Medical	1,416	11,501
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	Medical	705	3,232
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	Medical	93	345
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	Medical	412	1,252
92	INTERSTITIAL LUNG DISEASE W CC	Medical	24	214
93	INTERSTITIAL LUNG DISEASE W/O CC	Medical	4	25
94	PNEUMOTHORAX W CC	Medical	61	426
95	PNEUMOTHORAX W/O CC	Medical	36	133
96	BRONCHITIS & ASTHMA AGE >17 W CC	Medical	134	550
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	Medical	92	246
98	BRONCHITIS & ASTHMA AGE 0-17	Medical	949	2,691
99	RESPIRATORY SIGNS & SYMPTOMS W CC	Medical	69	232
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	Medical	56	259
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	Medical	62	248
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	Medical	41	250
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	Surgical	5	93
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	Surgical	11	91
106	CORONARY BYPASS W PTCA	Surgical	3	36
108	OTHER CARDIOTHORACIC PROCEDURES	Surgical	11	81
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	Surgical	32	285
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	Surgical	5	12
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	Surgical	13	239
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	Surgical	2	13
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	Surgical	3	31
119	VEIN LIGATION & STRIPPING	Surgical	1	4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	Surgical	7	64
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	Medical	129	859
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	Medical	145	497
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	Medical	57	169
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	Medical	81	193
126	ACUTE & SUBACUTE ENDOCARDITIS	Medical	20	269
127	HEART FAILURE & SHOCK	Medical	931	11,526
128	DEEP VEIN THROMBOPHLEBITIS	Medical	5	31
129	CARDIAC ARREST, UNEXPLAINED	Medical	11	24

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
130	PERIPHERAL VASCULAR DISORDERS W CC	Medical	224	1,338
131	PERIPHERAL VASCULAR DISORDERS W/O CC	Medical	76	536
132	ATHEROSCLEROSIS W CC	Medical	285	971
133	ATHEROSCLEROSIS W/O CC	Medical	112	1,178
134	HYPERTENSION	Medical	87	372
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	Medical	23	162
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	Medical	7	52
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	Medical	43	299
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	Medical	161	596
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	Medical	64	175
140	ANGINA PECTORIS	Medical	34	74
141	SYNCOPE & COLLAPSE W CC	Medical	103	285
142	SYNCOPE & COLLAPSE W/O CC	Medical	48	114
143	CHEST PAIN	Medical	613	1,221
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	Medical	185	1,136
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	Medical	75	1,469
146	RECTAL RESECTION W CC	Surgical	2	22
147	RECTAL RESECTION W/O CC	Surgical	2	13
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	Surgical	21	124
150	PERITONEAL ADHESIOLYSIS W CC	Surgical	16	128
151	PERITONEAL ADHESIOLYSIS W/O CC	Surgical	13	64
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	Surgical	6	47
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	Surgical	3	12
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	Surgical	10	32
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	Surgical	49	158
157	ANAL & STOMAL PROCEDURES W CC	Surgical	10	45
158	ANAL & STOMAL PROCEDURES W/O CC	Surgical	8	12
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	Surgical	21	86
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	Surgical	9	20
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	Surgical	1	1
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	Surgical	3	4
163	HERNIA PROCEDURES AGE 0-17	Surgical	4	15
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	Surgical	14	93
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	Surgical	17	70
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	Surgical	22	76
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	Surgical	65	116

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
168	MOUTH PROCEDURES W CC	Surgical	6	15
169	MOUTH PROCEDURES W/O CC	Surgical	4	12
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	Surgical	18	244
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	Surgical	5	18
172	DIGESTIVE MALIGNANCY W CC	Medical	60	624
173	DIGESTIVE MALIGNANCY W/O CC	Medical	122	2,293
174	G.I. HEMORRHAGE W CC	Medical	247	1,163
175	G.I. HEMORRHAGE W/O CC	Medical	47	132
176	COMPLICATED PEPTIC ULCER	Medical	55	384
177	UNCOMPLICATED PEPTIC ULCER W CC	Medical	30	107
178	UNCOMPLICATED PEPTIC ULCER W/O CC	Medical	24	92
179	INFLAMMATORY BOWEL DISEASE	Medical	113	584
180	G.I. OBSTRUCTION W CC	Medical	141	696
181	G.I. OBSTRUCTION W/O CC	Medical	61	188
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	Medical	786	2,852
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	Medical	357	1,037
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	Medical	811	2,155
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	Medical	57	177
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	Medical	47	114
187	DENTAL EXTRACTIONS & RESTORATIONS	Medical	2	3
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	Medical	239	1,476
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	Medical	133	412
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	Medical	143	486
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC	Surgical	10	100
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	Surgical	1	4
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	Surgical	3	15
195	CHOLECYSTECTOMY W C.D.E. W CC	Surgical	1	12
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	Surgical	8	30
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	Surgical	1	2
200	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	Surgical	1	27
201	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES	Surgical	1	4
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	Medical	252	2,007
203	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS	Medical	57	492
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	Medical	418	2,089
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	Medical	145	820
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	Medical	38	495

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
207	DISORDERS OF THE BILIARY TRACT W CC	Medical	157	669
208	DISORDERS OF THE BILIARY TRACT W/O CC	Medical	149	662
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	Surgical	41	283
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	Surgical	12	61
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	Surgical	16	76
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	Surgical	7	44
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	Surgical	11	73
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCULOSKELETAL & CONN TISS DIS	Surgical	32	341
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	Surgical	38	157
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	Surgical	40	133
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	Surgical	25	62
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	Surgical	12	32
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	Surgical	13	19
225	FOOT PROCEDURES	Surgical	11	30
226	SOFT TISSUE PROCEDURES W CC	Surgical	13	82
227	SOFT TISSUE PROCEDURES W/O CC	Surgical	8	25
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	Surgical	5	21
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	Surgical	2	3
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	Surgical	3	10
233	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W CC	Surgical	9	50
234	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W/O CC	Surgical	13	40
235	FRACTURES OF FEMUR	Medical	48	166
236	FRACTURES OF HIP & PELVIS	Medical	81	660
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	Medical	6	9
238	OSTEOMYELITIS	Medical	37	333
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	Medical	51	331
240	CONNECTIVE TISSUE DISORDERS W CC	Medical	34	186
241	CONNECTIVE TISSUE DISORDERS W/O CC	Medical	18	56
242	SEPTIC ARTHRITIS	Medical	17	150
243	MEDICAL BACK PROBLEMS	Medical	271	1,040
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	Medical	84	423
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	Medical	75	262
246	NON-SPECIFIC ARTHROPATHIES	Medical	5	14
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	Medical	46	288
248	TENDONITIS, MYOSITIS & BURSTITIS	Medical	37	271
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	Medical	84	593

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	Medical	19	79
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	Medical	14	29
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	Medical	16	26
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	Medical	72	307
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	Medical	59	174
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	Medical	40	82
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Medical	85	491
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	Surgical	4	8
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Surgical	4	10
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Surgical	1	2
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	Surgical	6	15
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	Surgical	1	2
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	Surgical	30	243
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	Surgical	20	96
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	Surgical	2	11
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	Surgical	3	8
267	PERIANAL & PILONIDAL PROCEDURES	Surgical	1	2
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	Surgical	4	8
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	Surgical	23	130
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	Surgical	15	59
271	SKIN ULCERS	Medical	57	607
272	MAJOR SKIN DISORDERS W CC	Medical	8	35
273	MAJOR SKIN DISORDERS W/O CC	Medical	18	186
274	MALIGNANT BREAST DISORDERS W CC	Medical	28	93
275	MALIGNANT BREAST DISORDERS W/O CC	Medical	96	1,483
276	NON-MALIGANT BREAST DISORDERS	Medical	29	105
277	CELLULITIS AGE >17 W CC	Medical	388	2,140
278	CELLULITIS AGE >17 W/O CC	Medical	229	823
279	CELLULITIS AGE 0-17	Medical	374	1,063
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	Medical	23	86
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	Medical	13	37
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	Medical	26	45
283	MINOR SKIN DISORDERS W CC	Medical	32	163
284	MINOR SKIN DISORDERS W/O CC	Medical	28	97
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	Surgical	9	65
286	ADRENAL & PITUITARY PROCEDURES	Surgical	8	49

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	Surgical	3	16
288	O.R. PROCEDURES FOR OBESITY	Surgical	21	49
289	PARATHYROID PROCEDURES	Surgical	2	3
290	THYROID PROCEDURES	Surgical	13	27
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	Surgical	7	83
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	Surgical	2	10
294	DIABETES AGE >35	Medical	266	1,138
295	DIABETES AGE 0-35	Medical	357	1,157
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	Medical	327	1,520
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	Medical	652	14,162
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	Medical	323	1,162
299	INBORN ERRORS OF METABOLISM	Medical	12	94
300	ENDOCRINE DISORDERS W CC	Medical	54	297
301	ENDOCRINE DISORDERS W/O CC	Medical	29	224
303	KIDNEY AND URETER PROCEDURES FOR NEOPLASM	Surgical	6	32
304	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC	Surgical	8	83
305	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC	Surgical	5	11
310	TRANSURETHRAL PROCEDURES W CC	Surgical	12	48
311	TRANSURETHRAL PROCEDURES W/O CC	Surgical	5	6
312	URETHRAL PROCEDURES, AGE >17 W CC	Surgical	1	8
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	Surgical	25	199
316	RENAL FAILURE	Medical	418	3,227
317	ADMIT FOR RENAL DIALYSIS	Medical	5	29
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	Medical	19	128
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	Medical	20	247
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	Medical	372	1,418
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	Medical	123	379
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	Medical	173	426
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	Medical	95	231
324	URINARY STONES W/O CC	Medical	33	73
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	Medical	7	26
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	Medical	3	8
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	Medical	3	9
328	URETHRAL STRICTURE AGE >17 W CC	Medical	2	9
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	Medical	74	436
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	Medical	34	568

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	Medical	21	67
334	MAJOR MALE PELVIC PROCEDURES W CC	Surgical	1	3
335	MAJOR MALE PELVIC PROCEDURES W/O CC	Surgical	5	14
336	TRANSURETHRAL PROSTATECTOMY W CC	Surgical	2	4
337	TRANSURETHRAL PROSTATECTOMY W/O CC	Surgical	2	5
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	Surgical	1	4
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	Surgical	1	1
341	PENIS PROCEDURES	Surgical	1	1
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	Surgical	1	37
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	Medical	5	27
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	Medical	9	160
348	BENIGN PROSTATIC HYPERTROPHY W CC	Medical	1	9
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	Medical	1	2
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	Medical	32	120
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	Medical	5	19
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	Surgical	1	1
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	Surgical	5	39
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	Surgical	7	14
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	Surgical	6	12
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	Surgical	1	13
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	Surgical	48	139
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	Surgical	93	190
360	VAGINA, CERVIX & VULVA PROCEDURES	Surgical	12	35
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	Surgical	5	12
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	Surgical	2	4
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	Surgical	2	34
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	Surgical	4	47
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	Medical	32	378
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	Medical	48	575
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	Medical	92	359
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	Medical	326	756
370	CESAREAN SECTION W CC	Maternity	477	1,809
371	CESAREAN SECTION W/O CC	Maternity	1,081	3,071
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	Maternity	1,806	5,453
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	Maternity	9,435	20,583
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Maternity	240	514

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	Maternity	3	6
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	Medical	248	788
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	Surgical	18	86
378	ECTOPIC PREGNANCY	Medical	26	46
379	THREATENED ABORTION	Medical	325	808
380	ABORTION W/O D&C	Medical	45	59
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Surgical	12	20
382	FALSE LABOR	Medical	24	30
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	Medical	832	2,262
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	Medical	92	198
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Newborn	396	8,050
387	PREMATURITY W MAJOR PROBLEMS	Newborn	298	4,100
388	PREMATURITY W/O MAJOR PROBLEMS	Newborn	899	4,467
389	FULL TERM NEONATE W MAJOR PROBLEMS	Newborn	678	4,292
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	Newborn	2,019	5,056
391	NORMAL NEWBORN	Newborn	8,774	17,481
392	SPLENECTOMY AGE >17	Surgical	7	78
393	SPLENECTOMY AGE 0-17	Surgical	3	7
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	Surgical	4	38
395	RED BLOOD CELL DISORDERS AGE >17	Medical	162	626
396	RED BLOOD CELL DISORDERS AGE 0-17	Medical	32	109
397	COAGULATION DISORDERS	Medical	46	160
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	Medical	38	169
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	Medical	39	261
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	Surgical	1	9
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	Medical	36	323
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	Medical	27	406
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	Medical	13	99
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	Surgical	1	5
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	Surgical	2	7
409	RADIOTHERAPY	Medical	6	53
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	Medical	162	694
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	Medical	11	73
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	Medical	14	265
417	SEPTICEMIA AGE 0-17	Medical	37	219
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	Medical	162	986

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	Medical	19	84
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	Medical	9	19
421	VIRAL ILLNESS AGE >17	Medical	22	52
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	Medical	243	513
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	Medical	40	362
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	Other	11	33
427	NEUROSES EXCEPT DEPRESSIVE	Other	2	3
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	Other	1	2
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	Other	408	9,420
430	PSYCHOSES	Other	10	28
439	SKIN GRAFTS FOR INJURIES	Surgical	1	9
440	WOUND DEBRIDEMENTS FOR INJURIES	Surgical	14	50
441	HAND PROCEDURES FOR INJURIES	Surgical	1	2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	Surgical	22	142
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	Surgical	9	17
444	TRAUMATIC INJURY AGE >17 W CC	Medical	28	114
445	TRAUMATIC INJURY AGE >17 W/O CC	Medical	13	152
446	TRAUMATIC INJURY AGE 0-17	Medical	12	41
447	ALLERGIC REACTIONS AGE >17	Medical	13	31
448	ALLERGIC REACTIONS AGE 0-17	Medical	3	6
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	Medical	433	1,354
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	Medical	129	184
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	Medical	86	160
452	COMPLICATIONS OF TREATMENT W CC	Medical	76	420
453	COMPLICATIONS OF TREATMENT W/O CC	Medical	44	244
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	Medical	17	102
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	Medical	8	26
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	Surgical	8	20
462	REHABILITATION	Medical	207	2,855
463	SIGNS & SYMPTOMS W CC	Medical	112	873
464	SIGNS & SYMPTOMS W/O CC	Medical	412	8,931
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Medical	1	5
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Medical	13	146
467	OTHER FACTORS INFLUENCING HEALTH STATUS	Medical	24	112
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Surgical	47	542
470	UNGROUPABLE	Other	46	290

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	Surgical	2	12
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	Surgical	34	591
475	NO LONGER VALID	Other	-	-
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Surgical	28	189
479	OTHER VASCULAR PROCEDURES W/O CC	Surgical	11	24
480	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	Other	1	21
481	BONE MARROW TRANSPLANT	Other	5	103
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	Surgical	13	163
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	2	44
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	9	82
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	34	455
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	Medical	117	803
488	HIV W EXTENSIVE O.R. PROCEDURE	Surgical	2	18
489	HIV W MAJOR RELATED CONDITION	Medical	51	431
490	HIV W OR W/O OTHER RELATED CONDITION	Medical	67	795
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	Surgical	7	18
492	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	Medical	22	254
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	Surgical	76	292
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	Surgical	76	197
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	Surgical	3	81
497	SPINAL FUSION EXCEPT CERVICAL W CC	Surgical	16	94
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	Surgical	58	168
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	Surgical	13	63
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	Surgical	18	39
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC	Surgical	1	5
503	KNEE PROCEDURES W/O PDX OF INFECTION	Surgical	5	21
504	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	Surgical	2	9
505	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	Medical	5	150
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	Surgical	4	108
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	Surgical	4	17
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	Medical	6	53
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	Medical	12	97
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	Medical	10	62
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	Medical	23	83
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	Surgical	15	112
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	Surgical	9	20

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
519	CERVICAL SPINAL FUSION W CC	Surgical	17	38
520	CERVICAL SPINAL FUSION W/O CC	Surgical	26	29
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	Other	68	237
523	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	Other	22	41
524	TRANSIENT ISCHEMIA	Surgical	77	210
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	Surgical	6	91
529	VENTRICULAR SHUNT PROCEDURES W CC	Surgical	4	25
530	VENTRICULAR SHUNT PROCEDURES W/O CC	Surgical	1	2
531	SPINAL PROCEDURES W CC	Surgical	8	56
532	SPINAL PROCEDURES W/O CC	Surgical	11	37
533	EXTRACRANIAL PROCEDURES W CC	Surgical	9	21
534	EXTRACRANIAL PROCEDURES W/O CC	Surgical	10	21
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	Surgical	2	33
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	Surgical	3	17
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	Surgical	10	61
538	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	Surgical	13	38
539	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	Surgical	2	8
541	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	Surgical	52	1,863
542	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	Surgical	24	711
543	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS	Surgical	2	45
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	Surgical	95	381
545	REVISION OF HIP OR KNEE REPLACEMENT	Surgical	12	59
546	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	Surgical	7	30
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	Surgical	10	101
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	Surgical	14	114
549	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	Surgical	6	64
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	Surgical	11	69
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	Surgical	6	28
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	Surgical	11	30
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	Surgical	13	74
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	Surgical	23	140
555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	Surgical	37	151
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	Surgical	9	27
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	Surgical	64	222
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	Surgical	61	129

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
559	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	Surgical	2	34
560	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	Medical	24	303
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	Medical	21	190
562	SEIZURE AGE > 17 W CC	Medical	213	709
563	SEIZURE AGE > 17 W/O CC	Medical	127	370
564	HEADACHES AGE >17	Surgical	121	320
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	Surgical	59	1,132
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS	Medical	87	628
567	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE > 17 W CC W MAJOR GI DX	Surgical	7	109
	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES PROC AGE > 17 W CC W/O MAJOR			
568	GI DX	Medical	13	95
569	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	Medical	41	638
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	Medical	32	247
571	MAJOR ESOPHAGEAL DISORDERS	Surgical	35	230
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	Medical	161	915
573	MAJOR BLADDER PROCEDURES	Surgical	6	51
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	Medical	37	204
575	SEPTICEMIA W MV96+ HOURS AGE >17	Surgical	11	164
576	SEPTICEMIA W/O MV96+ HOURS AGE >17	Medical	504	3,657
577	CAROTID ARTERY STENT PROCEDURE	Medical	3	4
578	INFECTIOUS & PARASITIC DISEASES W OR PROCEDURE	Medical	45	604
579	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W OR PROCEDURE	Surgical	27	190
Total			58,581	293,095

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
1	CRANIOTOMY AGE >17 W CC	Surgical	37	171
2	CRANIOTOMY AGE >17 W/O CC	Surgical	19	104
3	CRANIOTOMY AGE 0-17	Surgical	99	603
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	Surgical	25	157
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	Surgical	10	30
9	SPINAL DISORDERS & INJURIES	Medical	12	156
10	NERVOUS SYSTEM NEOPLASMS W CC	Medical	36	283
11	NERVOUS SYSTEM NEOPLASMS W/O CC	Medical	17	350
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	Medical	178	3,234
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	Medical	28	192
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	Medical	285	2,111
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	Medical	39	444
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	Medical	20	163
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	Medical	8	72
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	Medical	58	299
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	Medical	26	104
21	VIRAL MENINGITIS	Medical	41	138
22	HYPERTENSIVE ENCEPHALOPATHY	Medical	8	58
23	NONTRAUMATIC STUPOR & COMA	Medical	13	45
26	SEIZURE & HEADACHE AGE 0-17	Medical	257	862
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	Medical	25	144
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	Medical	19	88
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	Medical	12	103
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	Medical	32	108
31	CONCUSSION AGE >17 W CC	Medical	4	6
32	CONCUSSION AGE >17 W/O CC	Medical	4	6
33	CONCUSSION AGE 0-17	Medical	7	12
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	Medical	44	420
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	Medical	24	63
37	ORBITAL PROCEDURES	Surgical	6	20
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	Surgical	4	7
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	Surgical	6	44
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	Surgical	7	22
43	HYPHEMA	Other	-	-
44	ACUTE MAJOR EYE INFECTIONS	Medical	13	61
45	NEUROLOGICAL EYE DISORDERS	Medical	7	27
46	OTHER DISORDERS OF THE EYE AGE >17 W CC	Medical	9	24
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	Medical	6	7
48	OTHER DISORDERS OF THE EYE AGE 0-17	Medical	14	38
49	MAJOR HEAD & NECK PROCEDURES	Surgical	6	83
50	SIALOADENECTOMY	Surgical	1	2
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	Surgical	2	3
52	CLEFT LIP & PALATE REPAIR	Surgical	10	26
53	SINUS & MASTOID PROCEDURES AGE >17	Surgical	4	15
54	SINUS & MASTOID PROCEDURES AGE 0-17	Other	-	-

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	Surgical	5	17
56	RHINOPLASTY	Surgical	1	1
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	Surgical	2	11
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	Surgical	15	53
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	Surgical	1	2
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	Surgical	22	68
61	MYRINGOTOMY W TUBE INSERTION AGE >17	Surgical	1	8
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	Surgical	16	41
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	Surgical	38	135
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	Medical	44	492
65	DYSEQUILIBRIUM	Medical	21	78
66	EPISTAXIS	Medical	8	16
67	EPIGLOTTITIS	Medical	1	1
68	OTITIS MEDIA & URI AGE >17 W CC	Medical	23	78
69	OTITIS MEDIA & URI AGE >17 W/O CC	Medical	28	86
70	OTITIS MEDIA & URI AGE 0-17	Medical	166	521
71	LARYNGOTRACHEITIS	Medical	36	126
72	NASAL TRAUMA & DEFORMITY	Medical	1	3
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	Medical	36	256
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	Medical	19	104
75	MAJOR CHEST PROCEDURES	Surgical	86	755
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	Surgical	57	559
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	Surgical	6	41
78	PULMONARY EMBOLISM	Medical	85	501
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	Medical	84	675
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	Medical	11	41
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	Medical	28	286
82	RESPIRATORY NEOPLASMS	Medical	145	1,551
83	MAJOR CHEST TRAUMA W CC	Medical	6	16
84	MAJOR CHEST TRAUMA W/O CC	Other	-	-
85	PLEURAL EFFUSION W CC	Medical	29	210
86	PLEURAL EFFUSION W/O CC	Medical	5	12
87	PULMONARY EDEMA & RESPIRATORY FAILURE	Medical	112	1,069
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Medical	587	3,321
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	Medical	493	2,608
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	Medical	98	420
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	Medical	478	1,746
92	INTERSTITIAL LUNG DISEASE W CC	Medical	16	151
93	INTERSTITIAL LUNG DISEASE W/O CC	Medical	5	17
94	PNEUMOTHORAX W CC	Medical	28	131
95	PNEUMOTHORAX W/O CC	Medical	13	54
96	BRONCHITIS & ASTHMA AGE >17 W CC	Medical	146	633
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	Medical	200	665
98	BRONCHITIS & ASTHMA AGE 0-17	Medical	1,243	4,084
99	RESPIRATORY SIGNS & SYMPTOMS W CC	Medical	59	372

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	Medical	50	425
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	Medical	39	271
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	Medical	19	71
103	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	Other	7	109
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	Surgical	3	78
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	Surgical	48	405
106	CORONARY BYPASS W PTCA	Other	-	-
108	OTHER CARDIOTHORACIC PROCEDURES	Surgical	36	156
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	Surgical	72	757
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	Surgical	7	42
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	Surgical	38	977
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	Surgical	12	77
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	Surgical	4	61
118	CARDIAC PACEMAKER DEVICE REPLACEMENT	Surgical	3	10
119	VEIN LIGATION & STRIPPING	Surgical	1	5
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	Surgical	41	358
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	Medical	77	403
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	Medical	50	180
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	Medical	160	748
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	Medical	164	592
126	ACUTE & SUBACUTE ENDOCARDITIS	Medical	3	44
127	HEART FAILURE & SHOCK	Medical	815	4,924
128	DEEP VEIN THROMBOPHLEBITIS	Medical	1	16
129	CARDIAC ARREST, UNEXPLAINED	Medical	4	13
130	PERIPHERAL VASCULAR DISORDERS W CC	Medical	95	873
131	PERIPHERAL VASCULAR DISORDERS W/O CC	Medical	34	289
132	ATHEROSCLEROSIS W CC	Medical	96	330
133	ATHEROSCLEROSIS W/O CC	Medical	23	332
134	HYPERTENSION	Medical	102	408
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	Medical	8	54
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	Medical	1	30
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	Medical	15	139
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	Medical	78	274
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	Medical	44	148
140	ANGINA PECTORIS	Medical	36	117
141	SYNCOPE & COLLAPSE W CC	Medical	77	210
142	SYNCOPE & COLLAPSE W/O CC	Medical	40	101
143	CHEST PAIN	Medical	424	1,245
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	Medical	193	1,322
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	Medical	16	121
146	RECTAL RESECTION W CC	Surgical	3	19
147	RECTAL RESECTION W/O CC	Surgical	5	33
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	Surgical	21	164
150	PERITONEAL ADHESIOLYSIS W CC	Surgical	22	225
151	PERITONEAL ADHESIOLYSIS W/O CC	Surgical	13	77

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	Surgical	4	47
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	Surgical	8	58
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	Surgical	7	38
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	Surgical	66	362
157	ANAL & STOMAL PROCEDURES W CC	Surgical	14	88
158	ANAL & STOMAL PROCEDURES W/O CC	Surgical	11	26
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	Surgical	23	132
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	Surgical	33	141
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	Surgical	3	8
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	Surgical	3	13
163	HERNIA PROCEDURES AGE 0-17	Surgical	8	105
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	Surgical	25	240
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	Surgical	21	102
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	Surgical	20	68
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	Surgical	95	175
168	MOUTH PROCEDURES W CC	Surgical	1	3
169	MOUTH PROCEDURES W/O CC	Surgical	6	13
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	Surgical	24	214
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	Surgical	10	87
172	DIGESTIVE MALIGNANCY W CC	Medical	27	178
173	DIGESTIVE MALIGNANCY W/O CC	Medical	38	694
174	G.I. HEMORRHAGE W CC	Medical	206	1,052
175	G.I. HEMORRHAGE W/O CC	Medical	34	96
176	COMPLICATED PEPTIC ULCER	Medical	24	105
177	UNCOMPLICATED PEPTIC ULCER W CC	Medical	14	46
178	UNCOMPLICATED PEPTIC ULCER W/O CC	Medical	7	21
179	INFLAMMATORY BOWEL DISEASE	Medical	68	413
180	G.I. OBSTRUCTION W CC	Medical	90	641
181	G.I. OBSTRUCTION W/O CC	Medical	41	212
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	Medical	455	2,019
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	Medical	254	802
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	Medical	392	1,465
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	Medical	22	73
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	Medical	25	74
187	DENTAL EXTRACTIONS & RESTORATIONS	Medical	8	13
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	Medical	90	551
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	Medical	44	257
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	Medical	73	594
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC	Surgical	9	61
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	Surgical	5	27
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	Surgical	3	21
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	Surgical	3	12
195	CHOLECYSTECTOMY W C.D.E. W CC	Surgical	2	11
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	Surgical	16	99
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	Surgical	13	50

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
199	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	Surgical	2	12
200	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	Surgical	2	9
201	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES	Surgical	4	65
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	Medical	134	913
203	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS	Medical	53	518
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	Medical	205	1,127
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	Medical	64	367
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	Medical	22	94
207	DISORDERS OF THE BILIARY TRACT W CC	Medical	45	200
208	DISORDERS OF THE BILIARY TRACT W/O CC	Medical	26	92
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	Surgical	29	263
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	Surgical	16	73
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	Surgical	23	101
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	Surgical	4	35
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	Surgical	6	25
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCULOSKELET & CONN TISS DIS	Surgical	37	323
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	Surgical	25	168
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	Surgical	44	155
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	Surgical	52	155
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	Surgical	4	11
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	Surgical	13	38
225	FOOT PROCEDURES	Surgical	16	93
226	SOFT TISSUE PROCEDURES W CC	Surgical	6	32
227	SOFT TISSUE PROCEDURES W/O CC	Surgical	11	45
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	Surgical	5	28
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	Surgical	3	18
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	Surgical	6	58
232	ARTHROSCOPY	Surgical	3	9
233	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W CC	Surgical	16	78
234	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W/O CC	Surgical	17	55
235	FRACTURES OF FEMUR	Medical	24	148
236	FRACTURES OF HIP & PELVIS	Medical	20	193
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	Medical	1	10
238	OSTEOMYELITIS	Medical	38	361
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	Medical	20	159
240	CONNECTIVE TISSUE DISORDERS W CC	Medical	38	296
241	CONNECTIVE TISSUE DISORDERS W/O CC	Medical	21	92
242	SEPTIC ARTHRITIS	Medical	7	30
243	MEDICAL BACK PROBLEMS	Medical	84	344
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	Medical	14	75
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	Medical	8	41
246	NON-SPECIFIC ARTHROPATHIES	Medical	4	17
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	Medical	30	138
248	TENDONITIS, MYOSITIS & BURSITIS	Medical	23	118
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	Medical	10	64

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	Medical	2	4
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	Medical	6	30
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	Medical	4	7
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	Medical	28	140
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	Medical	13	92
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	Medical	18	69
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Medical	35	231
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	Surgical	10	21
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Surgical	8	21
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	Surgical	1	8
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Surgical	2	10
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	Surgical	2	3
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	Surgical	3	13
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	Surgical	32	383
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	Surgical	13	78
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	Surgical	6	42
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	Surgical	5	12
267	PERIANAL & PILONIDAL PROCEDURES	Surgical	3	7
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	Surgical	9	25
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	Surgical	41	260
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	Surgical	11	37
271	SKIN ULCERS	Medical	68	534
272	MAJOR SKIN DISORDERS W CC	Medical	10	88
273	MAJOR SKIN DISORDERS W/O CC	Medical	7	19
274	MALIGNANT BREAST DISORDERS W CC	Medical	7	48
275	MALIGNANT BREAST DISORDERS W/O CC	Medical	20	418
276	NON-MALIGANT BREAST DISORDERS	Medical	34	134
277	CELLULITIS AGE >17 W CC	Medical	215	1,021
278	CELLULITIS AGE >17 W/O CC	Medical	146	561
279	CELLULITIS AGE 0-17	Medical	327	1,076
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	Medical	8	18
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	Medical	11	90
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	Medical	16	33
283	MINOR SKIN DISORDERS W CC	Medical	33	191
284	MINOR SKIN DISORDERS W/O CC	Medical	24	93
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	Surgical	7	31
286	ADRENAL & PITUITARY PROCEDURES	Surgical	14	63
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	Surgical	12	187
288	O.R. PROCEDURES FOR OBESITY	Surgical	12	21
289	PARATHYROID PROCEDURES	Surgical	4	30
290	THYROID PROCEDURES	Surgical	17	51
291	THYROGLOSSAL PROCEDURES	Surgical	3	3
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	Surgical	9	88
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	Surgical	1	10
294	DIABETES AGE >35	Medical	249	1,003

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
295	DIABETES AGE 0-35	Medical	295	1,159
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	Medical	242	1,066
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	Medical	71	693
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	Medical	200	844
299	INBORN ERRORS OF METABOLISM	Medical	6	23
300	ENDOCRINE DISORDERS W CC	Medical	33	153
301	ENDOCRINE DISORDERS W/O CC	Medical	33	400
302	KIDNEY TRANSPLANT	Other	2	21
303	KIDNEY AND URETER PROCEDURES FOR NEOPLASM	Surgical	12	114
304	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC	Surgical	39	263
305	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC	Surgical	22	50
308	MINOR BLADDER PROCEDURES W CC	Surgical	3	12
309	MINOR BLADDER PROCEDURES W/O CC	Surgical	1	7
310	TRANSURETHRAL PROCEDURES W CC	Surgical	11	38
311	TRANSURETHRAL PROCEDURES W/O CC	Surgical	5	11
312	URETHRAL PROCEDURES, AGE >17 W CC	Other	-	-
313	URETHRAL PROCEDURES, AGE >17 W/O CC	Surgical	2	2
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	Surgical	35	420
316	RENAL FAILURE	Medical	274	1,824
317	ADMIT FOR RENAL DIALYSIS	Other	-	-
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	Medical	2	12
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	Medical	12	174
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	Medical	248	1,262
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	Medical	91	556
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	Medical	164	656
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	Medical	42	181
324	URINARY STONES W/O CC	Medical	11	28
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	Medical	9	29
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	Medical	3	33
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	Medical	4	9
328	URETHRAL STRICTURE AGE >17 W CC	Medical	1	2
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	Medical	65	379
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	Medical	10	32
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	Medical	23	119
334	MAJOR MALE PELVIC PROCEDURES W CC	Other	-	-
335	MAJOR MALE PELVIC PROCEDURES W/O CC	Surgical	4	13
336	TRANSURETHRAL PROSTATECTOMY W CC	Surgical	2	5
337	TRANSURETHRAL PROSTATECTOMY W/O CC	Other	-	-
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	Surgical	4	22
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	Surgical	3	3
341	PENIS PROCEDURES	Surgical	5	14
343	CIRCUMCISION AGE 0-17	Surgical	1	3
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	Surgical	3	23
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	Other	-	-
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	Medical	3	17

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	Medical	62	1,444
348	BENIGN PROSTATIC HYPERTROPHY W CC	Medical	2	38
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	Other	-	-
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	Medical	18	127
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	Medical	5	26
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	Surgical	6	31
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	Surgical	7	32
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	Surgical	11	25
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	Surgical	11	32
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	Surgical	3	10
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	Surgical	108	552
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	Surgical	237	594
360	VAGINA, CERVIX & VULVA PROCEDURES	Surgical	17	47
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	Surgical	8	29
362	ENDOSCOPIC TUBAL INTERRUPTION	Surgical	1	4
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	Surgical	17	59
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	Surgical	12	44
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	Surgical	8	36
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	Medical	14	49
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	Medical	2	3
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	Medical	80	284
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	Medical	119	409
370	CESAREAN SECTION W CC	Maternity	981	4,782
371	CESAREAN SECTION W/O CC	Maternity	2,191	7,626
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	Maternity	1,325	4,256
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	Maternity	6,319	15,308
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Maternity	157	424
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	Maternity	1	1
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	Medical	272	883
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	Surgical	28	123
378	ECTOPIC PREGNANCY	Medical	78	175
379	THREATENED ABORTION	Medical	251	736
380	ABORTION W/O D&C	Medical	78	192
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Surgical	50	94
382	FALSE LABOR	Medical	27	42
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	Medical	780	2,647
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	Medical	101	338
386	EXTREME IMMATUREITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Newborn	607	8,999
387	PREMATURITY W MAJOR PROBLEMS	Newborn	237	2,663
388	PREMATURITY W/O MAJOR PROBLEMS	Newborn	469	3,038
389	FULL TERM NEONATE W MAJOR PROBLEMS	Newborn	532	2,987
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	Newborn	729	2,234
391	NORMAL NEWBORN	Newborn	1,211	2,735
392	SPLENECTOMY AGE >17	Surgical	5	42
393	SPLENECTOMY AGE 0-17	Surgical	1	8

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	Surgical	6	29
395	RED BLOOD CELL DISORDERS AGE >17	Medical	466	2,662
396	RED BLOOD CELL DISORDERS AGE 0-17	Medical	145	603
397	COAGULATION DISORDERS	Medical	30	154
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	Medical	29	131
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	Medical	31	122
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	Surgical	4	22
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	Surgical	3	14
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	Medical	29	341
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	Medical	7	28
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	Medical	11	103
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	Surgical	4	72
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	Surgical	5	57
409	RADIOTHERAPY	Medical	3	16
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	Medical	97	428
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	Medical	4	33
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	Medical	2	4
417	SEPTICEMIA AGE 0-17	Medical	34	273
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	Medical	67	359
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	Medical	32	157
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	Medical	5	19
421	VIRAL ILLNESS AGE >17	Medical	18	76
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	Medical	141	490
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	Medical	20	196
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	Other	17	46
426	DEPRESSIVE NEUROSES	Other	2	5
427	NEUROSES EXCEPT DEPRESSIVE	Other	2	9
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	Other	1	2
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	Other	45	878
430	PSYCHOSES	Other	19	79
432	OTHER MENTAL DISORDER DIAGNOSES	Other	1	3
439	SKIN GRAFTS FOR INJURIES	Surgical	4	32
440	WOUND DEBRIDEMENTS FOR INJURIES	Surgical	12	73
441	HAND PROCEDURES FOR INJURIES	Surgical	3	6
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	Surgical	17	106
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	Surgical	18	83
444	TRAUMATIC INJURY AGE >17 W CC	Medical	7	64
445	TRAUMATIC INJURY AGE >17 W/O CC	Medical	6	18
446	TRAUMATIC INJURY AGE 0-17	Medical	7	13
447	ALLERGIC REACTIONS AGE >17	Medical	17	48
448	ALLERGIC REACTIONS AGE 0-17	Medical	4	13
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	Medical	180	636
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	Medical	72	138
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	Medical	49	179
452	COMPLICATIONS OF TREATMENT W CC	Medical	28	172

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
453	COMPLICATIONS OF TREATMENT W/O CC	Medical	27	99
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	Medical	24	97
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	Medical	10	32
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	Surgical	23	134
462	REHABILITATION	Medical	224	4,348
463	SIGNS & SYMPTOMS W CC	Medical	41	290
464	SIGNS & SYMPTOMS W/O CC	Medical	62	709
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Other	-	-
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Medical	1	8
467	OTHER FACTORS INFLUENCING HEALTH STATUS	Medical	23	153
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Surgical	120	1,547
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	Medical	1	2
470	UNGROUPABLE	Other	222	2,210
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	Surgical	4	21
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	Surgical	22	394
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Surgical	1	5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Surgical	56	471
479	OTHER VASCULAR PROCEDURES W/O CC	Surgical	31	67
480	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	Other	8	65
481	BONE MARROW TRANSPLANT	Other	11	244
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	Surgical	23	228
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	7	61
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	21	177
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	Surgical	59	393
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	Medical	35	334
488	HIV W EXTENSIVE O.R. PROCEDURE	Surgical	7	208
489	HIV W MAJOR RELATED CONDITION	Medical	315	2,514
490	HIV W OR W/O OTHER RELATED CONDITION	Medical	57	436
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	Surgical	7	31
492	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	Medical	55	397
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	Surgical	114	543
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	Surgical	114	343
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	Other	-	-
497	SPINAL FUSION EXCEPT CERVICAL W CC	Surgical	2	12
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	Surgical	7	28
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	Surgical	4	30
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	Surgical	13	36
501	KNEE PROCEDURES W PDX OF INFECTION W CC	Surgical	4	56
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC	Surgical	1	4
503	KNEE PROCEDURES W/O PDX OF INFECTION	Surgical	6	22
504	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	Surgical	8	144
505	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	Medical	2	13
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	Surgical	5	42
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	Surgical	6	32
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	Medical	5	22

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	Medical	4	11
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	Medical	7	98
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	Medical	48	250
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	Surgical	29	259
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	Surgical	34	90
519	CERVICAL SPINAL FUSION W CC	Surgical	11	116
520	CERVICAL SPINAL FUSION W/O CC	Surgical	9	36
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	Other	49	217
523	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	Other	10	15
524	TRANSIENT ISCHEMIA	Surgical	76	257
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	Surgical	5	49
529	VENTRICULAR SHUNT PROCEDURES W CC	Surgical	4	27
530	VENTRICULAR SHUNT PROCEDURES W/O CC	Surgical	4	29
531	SPINAL PROCEDURES W CC	Surgical	7	36
532	SPINAL PROCEDURES W/O CC	Surgical	8	35
533	EXTRACRANIAL PROCEDURES W CC	Surgical	8	46
534	EXTRACRANIAL PROCEDURES W/O CC	Surgical	10	22
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	Surgical	3	7
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	Other	-	-
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	Surgical	11	53
538	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	Surgical	17	55
539	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	Surgical	4	40
540	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	Surgical	2	20
541	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	Surgical	52	1,461
542	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	Surgical	95	2,181
543	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS	Surgical	16	99
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	Surgical	93	443
545	REVISION OF HIP OR KNEE REPLACEMENT	Surgical	8	51
546	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	Surgical	22	93
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	Surgical	10	100
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	Surgical	23	185
549	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	Surgical	18	170
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	Surgical	18	127
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	Surgical	11	83
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	Surgical	16	82
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	Surgical	51	508
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	Surgical	59	499
555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	Surgical	57	264
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	Surgical	12	48
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	Surgical	41	349
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	Surgical	43	153
559	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	Surgical	2	9
560	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	Medical	30	315
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	Medical	22	148

Inpatient Report By DRG

DRG Code	Description	Category	Admissions	Days
562	SEIZURE AGE > 17 W CC	Medical	187	862
563	SEIZURE AGE > 17 W/O CC	Medical	123	357
564	HEADACHES AGE >17	Surgical	111	399
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	Surgical	75	1,177
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS	Medical	116	700
567	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE > 17 W CC W MAJOR GI DX	Surgical	6	93
	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES PROC AGE > 17 W CC W/O MAJOR GI			
568	DX	Medical	20	126
569	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	Medical	69	750
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	Medical	46	571
571	MAJOR ESOPHAGEAL DISORDERS	Surgical	27	134
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	Medical	75	440
573	MAJOR BLADDER PROCEDURES	Surgical	2	13
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	Medical	41	254
575	SEPTICEMIA W MV96+ HOURS AGE >17	Surgical	35	421
576	SEPTICEMIA W/O MV96+ HOURS AGE >17	Medical	241	2,392
577	CAROTID ARTERY STENT PROCEDURE	Medical	5	42
578	INFECTIOUS & PARASITIC DISEASES W OR PROCEDURE	Medical	48	660
579	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W OR PROCEDURE	Surgical	36	287
			39,060	195,898